

CERTIFICATE OF DEATH

Reg. Dist. No.

11016

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1324 Church Hill Drive.		d. STREET ADDRESS 1324 Church Hill Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle ABRAMS Last		4. DATE OF DEATH Month 10/19/61 Day 19 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Bare Goldscheider		14. MOTHER'S MAIDEN NAME Frieda ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Rose Kandell-- Same	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 30 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 58 to Oct 19, 1961 , that I last saw the deceased alive on Oct 19, 1961 , and that death occurred at 5 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Joseph Gross M.D.		6911 Park Lane A. D. H. 10/19/61	
PHYSICIAN'S NAME (Type) JOSEPH GROSS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/20/61	22c. NAME OF CEMETERY OR CREMATOR Ohr Knesseth Israel Anshe	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC.		ADDRESS 6010 Reisterstown Rd.	
24a. RECEIVED BY REGISTRAR Oct 23 1961		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

1

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1891

1891

1891

1891

1891

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

11025 11017
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>—</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maryland Masonic Home</i>		d. STREET ADDRESS <i>431 N Clinton St.</i>	
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Henry</i> Middle <i>Adams, Sr.</i> Last		4. DATE OF DEATH <i>Oct.</i> Month <i>23</i> Day <i>1961</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 21, 1865</i>
9. AGE (In years last birthday) <i>95</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blacksmith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Benjamin Adams</i>		14. MOTHER'S MAIDEN NAME <i>Fanny Jarvis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>218-32-2918</i>	
17. INFORMANT <i>Masonic Home Records - Cockeysville, Md.</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular</i> DUE TO <i>422</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Obstruction</i> DUE TO (c) <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>at least 12 yrs.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Oct 15 1961</i> to <i>Oct 23 1961</i> that (I) (we) last saw the deceased alive on <i>Oct 23 1961</i> , and that death occurred at <i>11:15</i> M, from the causes and on the date stated above.	
22a. SIGNATURE <i>Elizabeth B. Sherrill</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherrill, MD</i>		22d. ADDRESS <i>Cockeysville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-25-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Stiff Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Urbana, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 12</i> ADDRESS		25a. REC'D BY REGISTRAR <i>OCT 25 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

(M)

(I)

MEDICAL CERTIFICATION

1011

RECEIVED

1032

(1)

TO THE HONORABLE SECRETARY OF THE
NAVY
WASHINGTON, D. C.
DEAR SIR:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. M. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11026

11018

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X PARRVILLE TOWSON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1439 PUTTY HILL RD.				d. STREET ADDRESS 1 1439 Putty Hill Rd.			
3. NAME OF DECEASED (Type or print) CATHERINE M. Andrathy				4. DATE OF DEATH Oct 1 1961			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-20-1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 MRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT home				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis J. Trier				14. MOTHER'S M maiden NAME ANNIE FENTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. BERNARD L. ANDRATHY			
17. INFORMANT SAME				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Marked Dehydration and wasting							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 5, 1958 to Sept 1, 1961 , that (I) last saw the deceased alive on Sept 30, 1961 , and that death occurred at 5 PM , from the causes and on the date stated above.							
22a. SIGNATURE Joseph F. Lippa M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-1-61	
22c. PHYSICIAN'S NAME (Type) JOSEPH F. LIPPA				22d. ADDRESS 8400 North Raven Blvd, Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/4/61		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town or county) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. J. Ruck				ADDRESS 5305 HARFORD Rd.		25a. REC'D BY REGISTRAR OCT 3 '61	
						25b. REGISTRAR'S SIGNATURE C. J. L. KRAUS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11027

CERTIFICATE OF DEATH

Reg. Dist. No. 11019

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b <u>Middle River</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1125 Ormes Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Elken North Carolina</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>1125 Ormes Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Anthony</u> Last <u>Anthony</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1873</u>
9. AGE (In years last birthday) <u>88</u>		10. IF UNDER 1 YEAR Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>	11. IF UNDER 24 HRS. Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elkin North Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Willie Cockerham</u>		14. MOTHER'S MAIDEN NAME <u>Emeline Willey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Mallory V. Anthony</u>		Address <u>1125 Ormes Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic cerebrovascular disease</u> 321X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>321X</u> DUE TO (c) <u>321X</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1960, to <u>Oct 23, 1961</u> , that I last saw the deceased alive on <u>Oct 23</u> , 1961, and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Semenovoff</u>		ADDRESS (Street, city or town, state) <u>2108 Ormes Rd Baltimore 20, Md</u>	
DATE SIGNED <u>10/23/61</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVOFF</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-25-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elkin North Carolina</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louisa J. J. H. 7701 Belair Road</u>		ADDRESS <u>Elkin North Carolina</u>	
24a. REC'D BY REGISTRAR <u>OCT 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1863

CERTIFICATE OF DEATH

1863

[The following text is extremely faint and largely illegible due to fading and bleed-through from the reverse side of the page. It appears to be a formal certificate of death, containing fields for name, age, date of death, and place of death, followed by a signature line.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11020

11030

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON DC. DC.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC.	
f. STREET ADDRESS 1407 KENNEDY STR.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HORACE W. BARBER		4. DATE OF DEATH Month 10 Day 12 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1881
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - V.P. Suburban		10b. KIND OF BUSINESS OR INDUSTRY Title & Inv Co.	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME SAMUEL H. BARBER		14. MOTHER'S MAIDEN NAME EWHA HART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-01-4980A	
17. INFORMANT Personal History		Address AA Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO ARTERIOSCLEROSIS, GENERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS 002X INTERVAL BETWEEN ONSET AND DEATH unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 10-4 , 19 61 , to 10-12 , 19 61 , that I last saw the deceased alive on 10-11 , 19 61 , and that death occurred at 1225 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Milton B. Kress M.D.			
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D. Eudowood Sanatorium, Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/14/61	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES - CO.		24a. REC'D BY REGISTRAR 2901-1475 ST. NW. WASH, D.C.	
24b. REGISTRAR'S SIGNATURE Clairmont L. Hines		DATE OCT 18 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11031

11021

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lower Bechtelville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Edward</u> Last <u>Baumbach</u>		4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Utilities</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Baumbach</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Sinclair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-30-5847</u>	
17. INFORMANT <u>Mrs Myrtle Baumbach</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 21</u> 19 <u>61</u> to <u>Oct 21</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 21</u> 19 <u>61</u> , and that death occurred at <u>7:55 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E Bush</u>		22b. DATE SIGNED <u>10-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E Bush MD</u>		22d. ADDRESS <u>HAMPSTEAD Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace</u>		23d. LOCATION (City, town, or county) (State) <u>Buried Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - 2nd - Hampstead Md</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 27 '61</u>	
ADDRESS <u> </u>		25b. REGISTRAR'S SIGNATURE <u>C. L. & K. K.</u>	



4
FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH

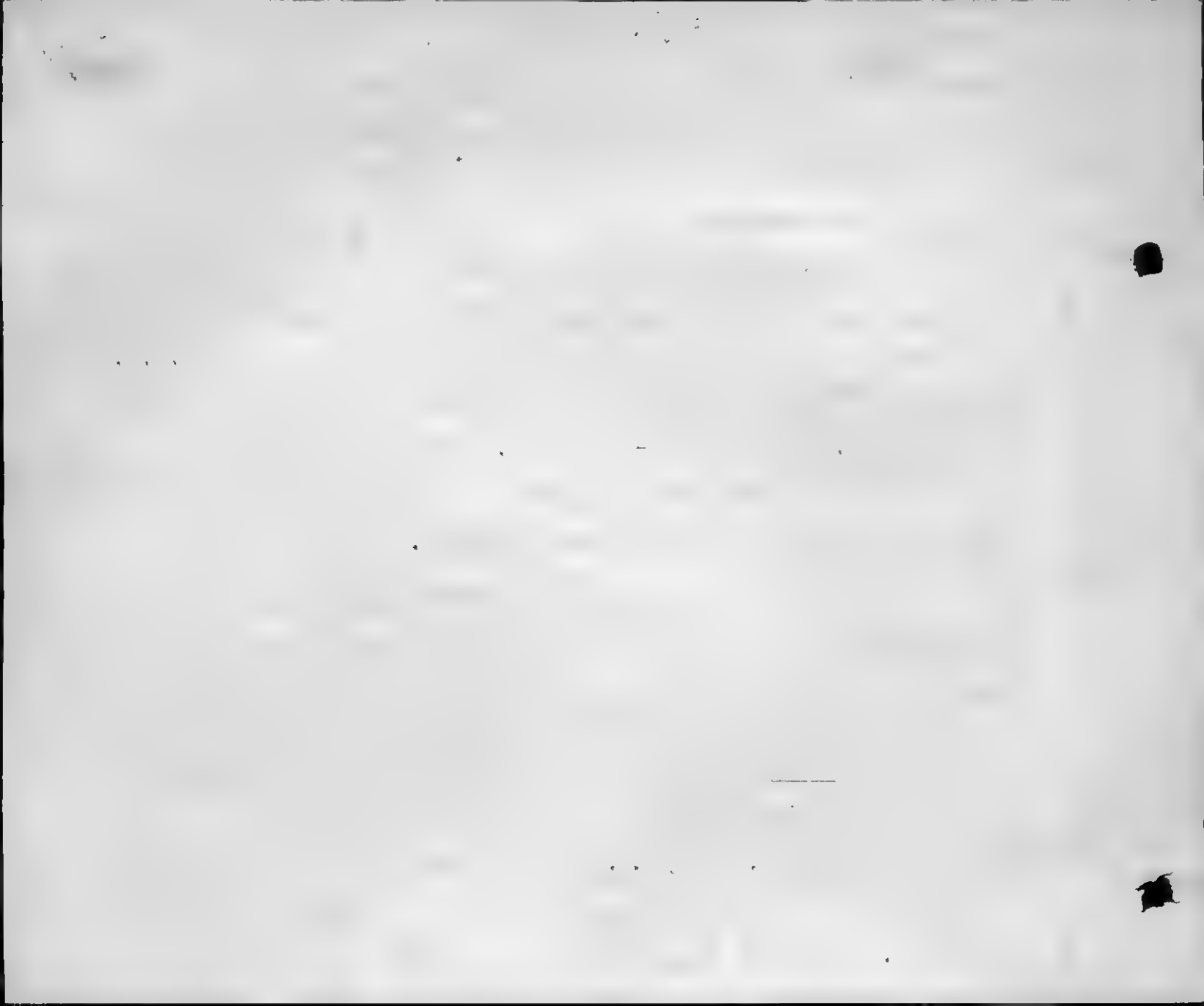
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11022

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY 11		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 8008 Harford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES LEE BEAN		4. DATE OF DEATH October 26 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1928		9. AGE (in years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min. 33			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY North Carolina		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Monroe Bean		14. MOTHER'S MAIDEN NAME May Barbee		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 245-32-7305			
17. INFORMANT Mrs. May Bean		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Thrombosis. DUE TO (c) 4201		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21a. ACTUAL SIGNATURE Charles S. Petty		21b. EXAMINER'S NAME (Type) Charles S. Petty, M.D.		21c. DATE SIGNED 10/27/61		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR Leonard J. Ruck		23a. ADDRESS 2205 Harford Road #14		24a. REC'D BY REGISTRAR OCT 30 '61		24b. REGISTRAR'S SIGNATURE Arthur E. Hume		25. MEDICAL CERTIFICATION		26. MEDICAL CERTIFICATION		27. MEDICAL CERTIFICATION		28. MEDICAL CERTIFICATION			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

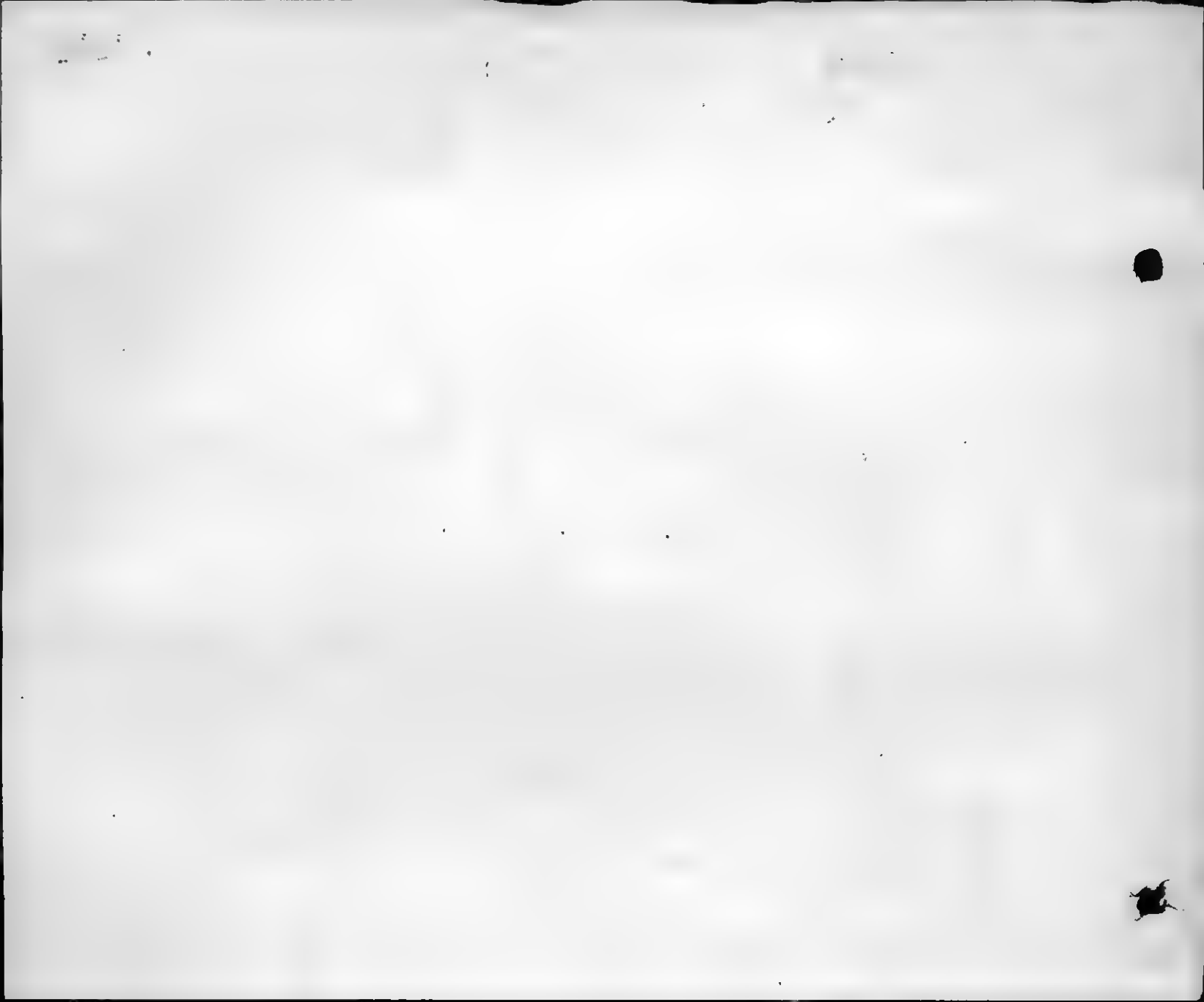
CERTIFICATE OF DEATH

Reg. Dist. No.

11033

11023

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 89 Willow Spring Road		d. STREET ADDRESS 89 Willow Spring Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle EARLE Last BEARRY		4. DATE OF DEATH Month October Day 17 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1895
9. AGE (In years lost birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipb ulder	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Bearry		14. MOTHER'S MAIDEN NAME Cassie M. McKenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 216-10-4061	
17. INFORMANT Wm/ E. Bearry 2116 Merritt Blvd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 162.1 IMMEDIATE CAUSE (a) Primary carcinoma lungs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) carcinomatosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 mos. 7 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5, 1961 to Oct 17, 1961 , that I last saw the deceased alive on Oct 17, 1961 , and that death occurred at 4 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE David H. Andrew M.D.		ADDRESS (Street, city or town, state) 33 Dundalk Ave	
PHYSICIAN'S NAME (Type) David H. Andrew		DATE SIGNED 10/15/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/61	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE OCT 20 '61	
24b. REGISTRAR'S SIGNATURE Arthur J. Kline			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11034

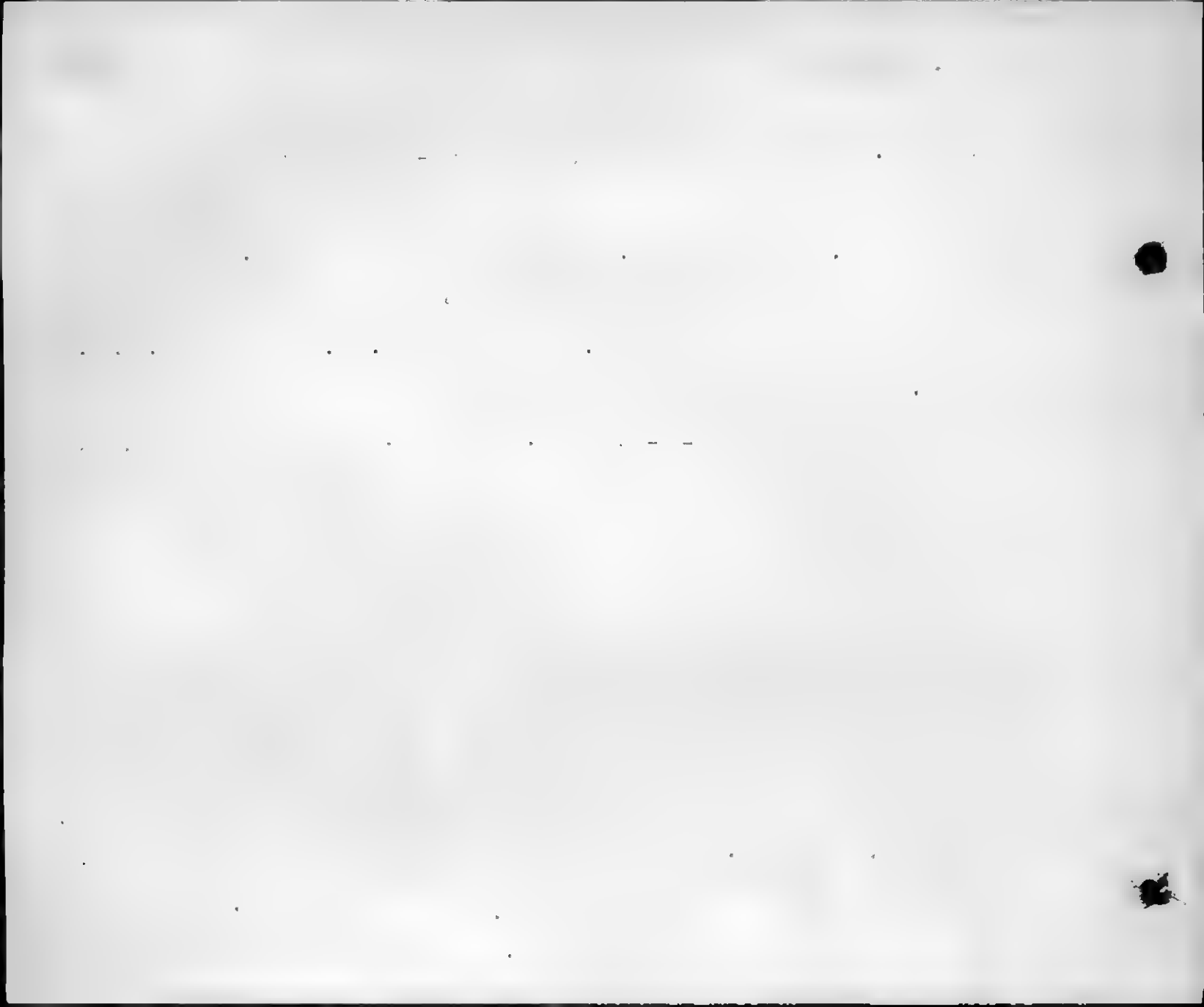
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11024

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Reisterstown				c. LENGTH OF STAY IN 1b Since July, 1961			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer Park Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mr. Harry Middle F. Last Becraft				4. DATE OF DEATH Month Oct. Day 2 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1888	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	IF UNDER 24 HRS Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Weaver		10b. KIND OF BUSINESS OR INDUSTRY Textile Bus.		11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Becraft				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-1994		17. INFORMANT Mrs. Margaret W. Becraft, Reisterstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 15 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 16, 1961 to October 2, 1961 , that (I) (we) last saw the deceased alive on October 2, 1961 , and that death occurred at 3:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE Clarence E. McWilliams				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED October 2, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Clarence E. McWilliams				22d. ADDRESS 11904 Reisterstown Rd. Reisterstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/61		23c. NAME OF CEMETERY OR CREMATORY Old Oakland M.E. Church		23d. LOCATION (City, town, or county) (State) Carroll Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				25a. REC'D BY REGISTRAR DATE OCT 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

I

M

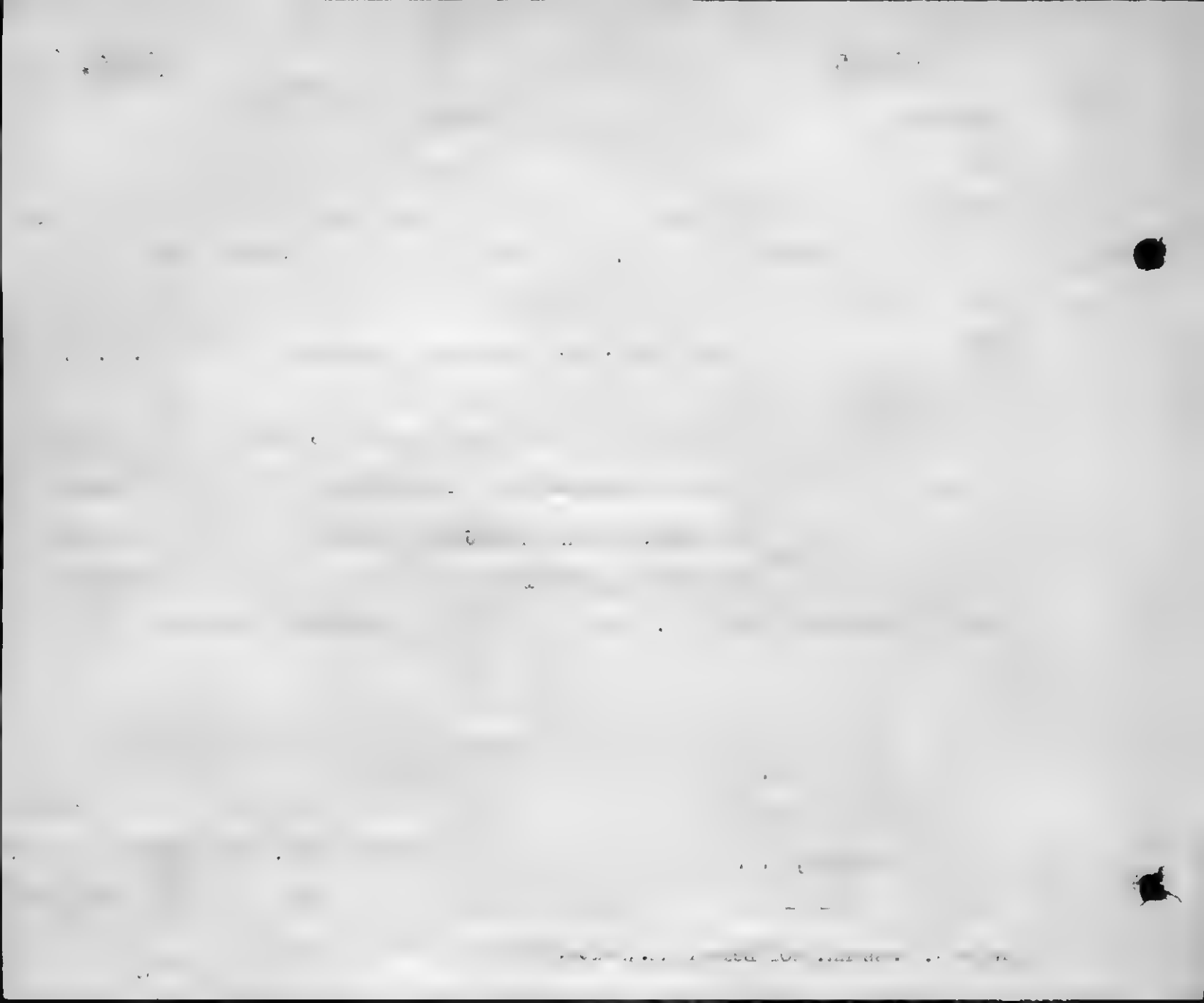


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11035 CERTIFICATE OF DEATH 11025											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 15 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4315 Raspe Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLES R.						4. DATE OF DEATH October 26 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 4, 1887		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 26 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter				10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. Co.				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Otto Behrmann						14. MOTHER'S MAIDEN NAME Rosina Lober					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I						16. SOCIAL SECURITY NO. 213-05-3196		17. INFORMANT Clinical Records VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTEROLATERAL MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (b) LEFT CORONARY ATHEROMATOUS OCCLUSION (a), stating the underlying cause last PROSTATIC ADENOCARCINOMA (c) UNKNOWN										INTERVAL BETWEEN ONSET AND DEATH 5 HOURS +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Bronchopneumonia, Right Lung. Operation 10/19/61-Transurethral Resection										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that Dr. (this hospital) attended the deceased from October 11 1961 to October 26 1961 , that we last saw the deceased alive on Oct. 26 1961 , and that death occurred at 1:25 AM , from the causes and on the date stated above.											
22a. SIGNATURE Sebastian Russo						22b. DATE SIGNED 10/26/61		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.			
22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE THEREOF 10-30-1961		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Edgar F. Lassehn, 7401 Belair Rd., Balto. Maryland						25a. REC'D BY REGISTRAR OCT 30 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

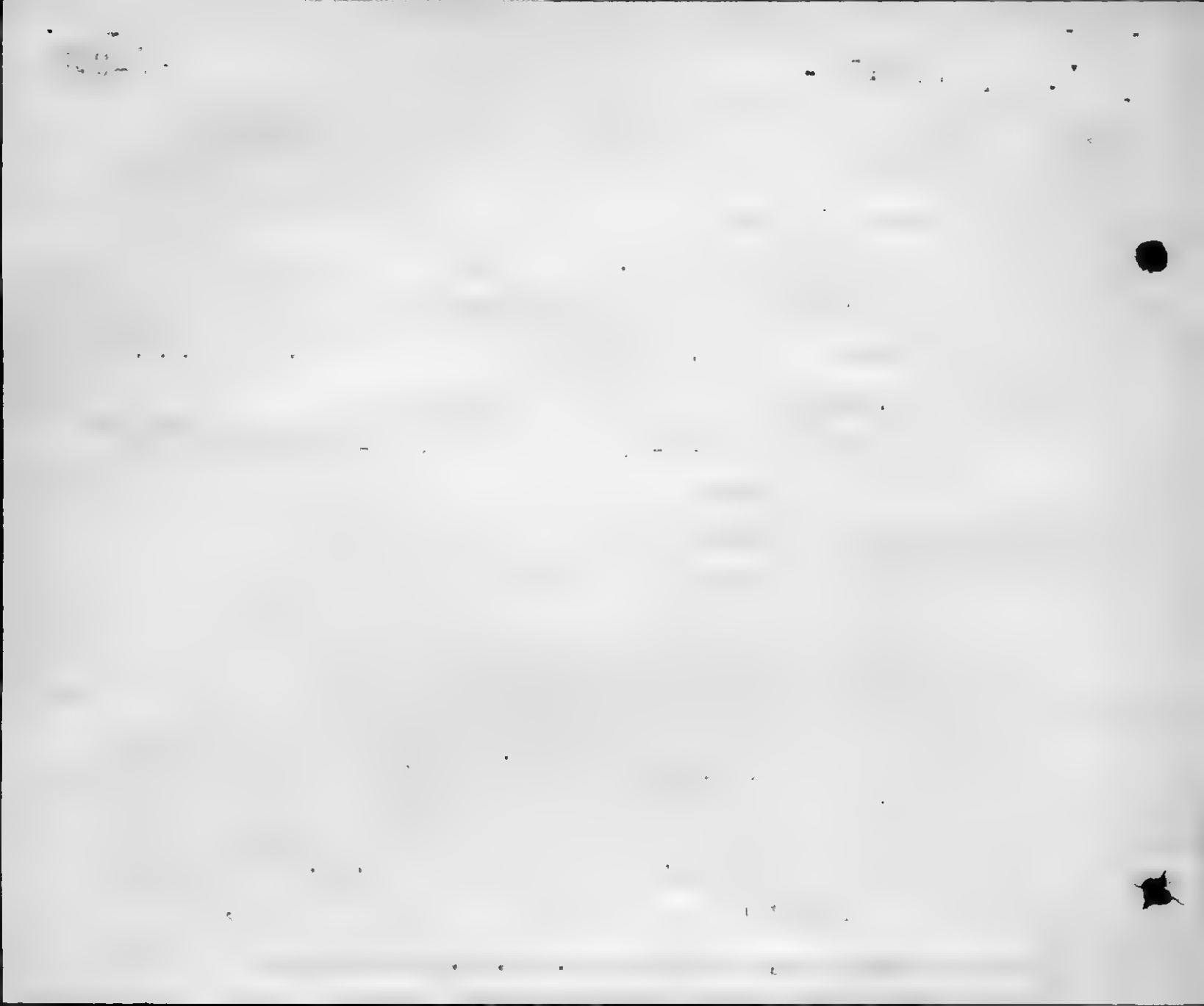
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11036

11026

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 27</u> d. STREET ADDRESS <u>5541 Dolores Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN R. BELL</u> 4. DATE OF DEATH <u>October 21 1961</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>February 19, 1923</u> 9. AGE (In years, last birthday) <u>38</u> yrs. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aviation Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Agriculture</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>Waynesboro, Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leroy C. Bell</u> 14. MOTHER'S MAIDEN NAME <u>Elsie Stoops</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW II</u> 16. SOCIAL SECURITY NO. <u>215-12-7431</u> 17. INFORMANT <u>Clinical Records</u> address <u>VA Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>UREMIA</u> 445X DUE TO (b) <u>NEPHROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>MALIGNANT HYPERTENSION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 19, 1961</u> to <u>Oct. 21, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 21, 1961</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Elijah Saunders</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>ELIJAH SAUNDERS, M. D.</u>		22b. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIVISION</u> 22d. DATE SIGNED <u>10/22/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10/25/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore 28, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>HUBBARD Funeral Home</u> ADDRESS <u>1107 Wilkins Ave Balto. Md.</u> 25a. REC'D BY REGISTRAR <u>OCT 24 '61</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

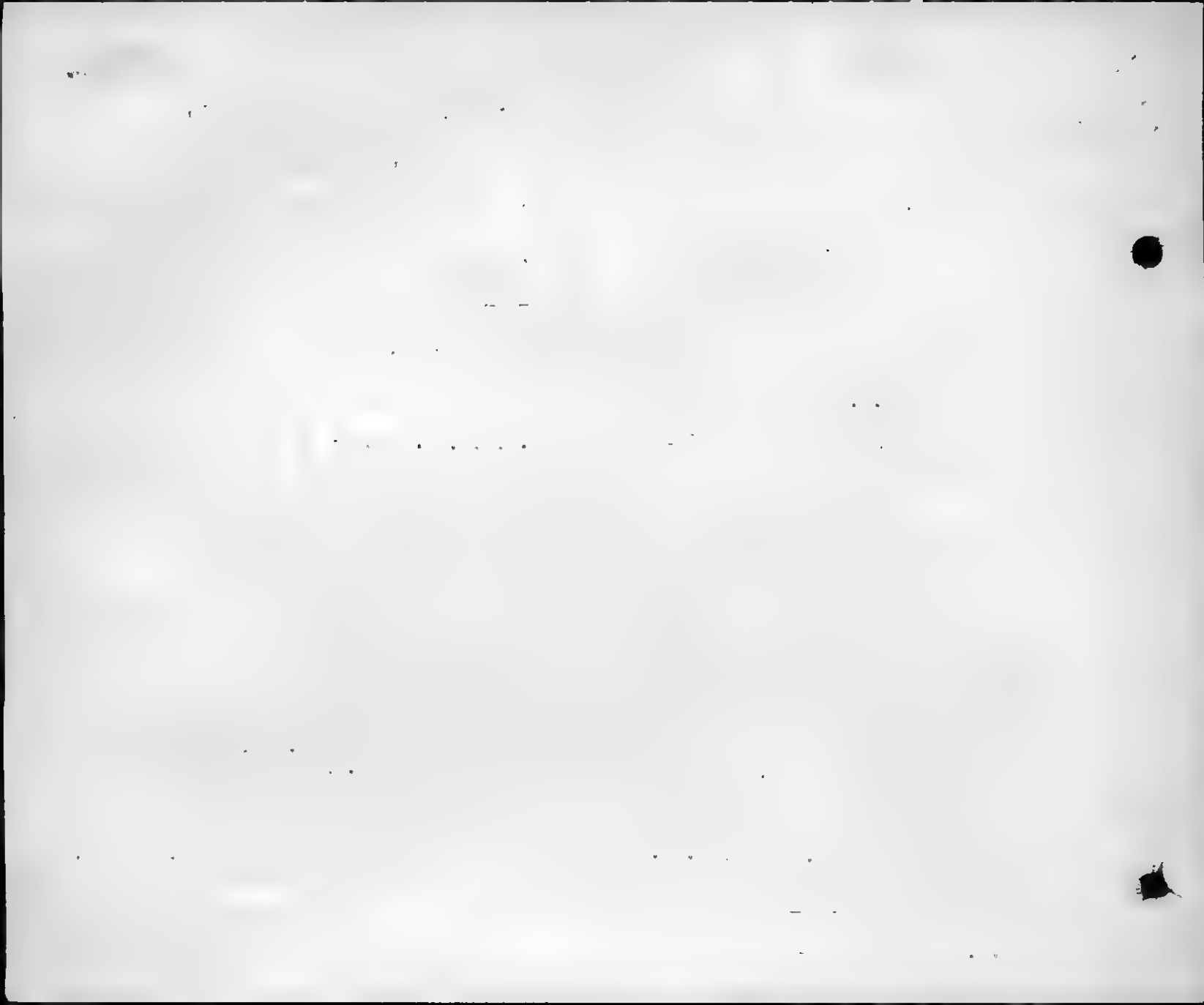


1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11037

11027

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harlem Lodge				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle Edmund Last LEE				4. DATE OF DEATH Month OCT. Day 15 Year 1961			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1906	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Funeral Supplies		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? Salesman				13. FATHER'S NAME Robert E. L. Berger			
14. MOTHER'S MAIDEN NAME Celine Bond				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. 240-10-3934				17. INFORMANT Mrs. R. E. L. Berger			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Brain Tumor. Astrocytoma 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 193.0 DUE TO (c) 193.0 DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from April 29, 1960 to Oct. 15, 1961 , that (I) (we) last saw the deceased alive on Oct. 14, 1961 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Harry L. Knipp				22b. DATE SIGNED 10/16/61			
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M.D.				22d. ADDRESS 4116 Ardrosson Avenue Balto. 29, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-61		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City, town, or county) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				25a. REC'D BY REGISTRAR OCT 18 '61		25b. REGISTRAR'S SIGNATURE C. L. H. H.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

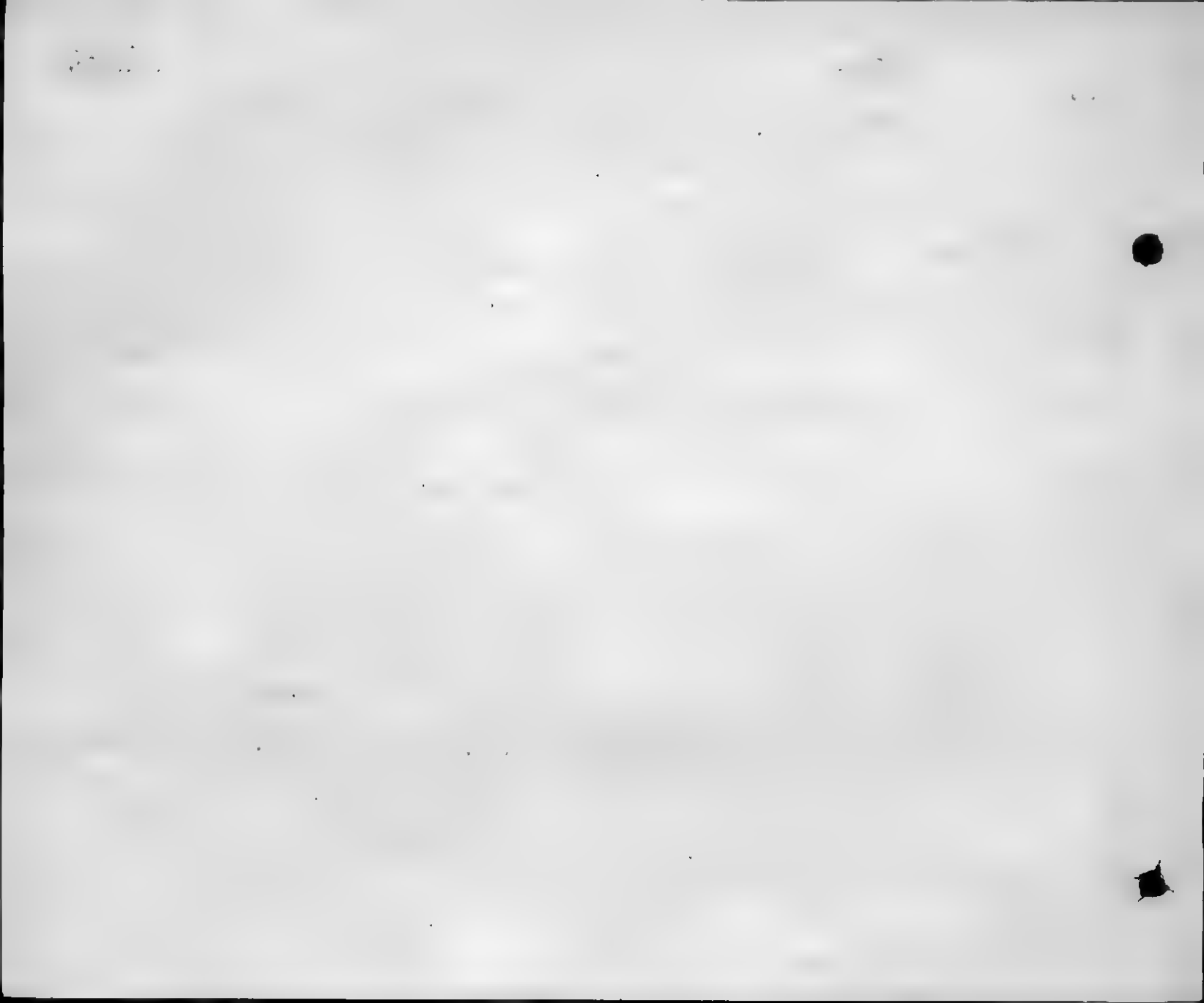
11038

11028

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b 66yrs3dys	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fredericka		4. DATE OF DEATH Last October 11		5. SEX female	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1867	
9. AGE (In years last birthday) 93		10. BIRTHPLACE (County & State, or foreign country) Germany		11. CITIZEN OF WHAT COUNTRY? Germany	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		13. KIND OF BUSINESS OR INDUSTRY canning factory		14. MOTHER'S MAIDEN NAME Anne Margaret Golderman	
15. FATHER'S NAME Peter Berkes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 4-2-2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 8, 1895 to Oct. 11, 1961 , that (we) last saw the deceased alive on Oct. 11, 1961 , and that death occurred at 3:10p. from the causes and on the date stated above.					
22a. SIGNATURE Stella Wachslar, M. D.		22b. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		22c. DATE SIGNED 10-11-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY First United Evan. Cemetery	
23d. LOCATION (City, town or county) Baltimore, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR OCT 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Fina					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11039					11029				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Baltimore			a. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore			b. COUNTY		Baltimore		
c. LENGTH OF STAY IN		Baltimore			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Forest Haven Nursing Home			d. STREET ADDRESS		1074 Craftswood Rd.		
3. NAME OF DECEASED (Type or print)		Fannie Isabella Bieswanger			4. DATE OF DEATH		October 26, 1961		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.	
female		white				Jan. 4, 1886		75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
retired		Dressmaker		Baltimore, Md.		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Clarence Shelley		Isabella Godfrey		no		216-07-8903		Lillian E. Morris 1074 Craftswood Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED?		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
260X DUE TO				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				(County)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(State)	
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY									
Hour a.m. p.m.									
20d. INJURY OCCURRED									
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)									
(County)									
(State)									
21. I certify that (I) (this hospital) attended the deceased from Aug 31, 1961 to Oct 26, 1961, that (I) (we) last saw the deceased alive on Aug 26, 1961, and that death occurred at 9 PM, from the causes and on the date stated above.									
22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. REC'D BY REGISTRAR	
Paul M. Byerly, M.D.				Paul M. Byerly, M.D.		5820 York Road		OCT 30 '61	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		23e. REGISTRAR'S SIGNATURE	
Burial		10/30/61		Woodlawn Cemetery		Baltimore, Md.		Arthur S. King	
24. FUNERAL DIRECTOR'S SIGNATURE		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard 4107 Wilkens Ave. #29				DATE OCT 30 '61					

112

11

11

11

11

11

11

11

11

11

11

11

11

11

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11040

11030

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Randallstown			c. LENGTH OF STAY IN 1b 6 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3611 Blackstone Road				d. STREET ADDRESS 3611 Blackstone Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mr. Frederick Max Bishop				4. DATE OF DEATH Month Day Year Oct. 6 1961			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1872		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY American Brakeshoe & Foundry		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-05-2654		17. INFORMANT Mr. Otto W. Bishop, 3611 Blackstone Rd. Randallstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO Coronary Artery Disease (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1954 to Oct 6, 1961 , that (I) (we) last saw the deceased alive on Oct 6, 1961 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Thomas E. Wheeler				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas E. Wheeler				22d. ADDRESS 3601 Clifmar Rd. Balto. 7, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-9-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Randallstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				25a. REC'D BY REGISTRAR Oct 10 1961		25b. REGISTRAR'S SIGNATURE Arthur J. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the medical records retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

11031

11041

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN <u>1 month</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>177 Winters Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>177 Winter ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hattie E. Blackwell</u> First Middle Last 4. DATE OF DEATH <u>Oct-7-1961</u> Month Day Year				5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 7, 1885</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John H. Thorne</u>			
14. MOTHER'S MARRIED NAME <u>Martha - unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Ada Webb - 177 Winters ave, Catonsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> DUE TO (b) <u>Hypertensive Cardio-Renal Disease</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 1st, 1961</u> to <u>Oct. 7th, 1961</u> , that I last saw the deceased alive on <u>Oct. 7th, 1961</u> , and that death occurred at <u>5.30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Winters Lane Catonsville, 28. Md.</u> DATE SIGNED <u>10/7/61</u>							
ACTUAL SIGNATURE <u>C. F. Maloney, M.D.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>C F. Maloney, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>10/10/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u> 22d. LOCATION (City, town, or county) (State) <u>Lanham Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Snowden</u> ADDRESS <u>Rockville Md.</u> 24a. REC'D BY REGISTRAR DATE <u>OCT 13 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11042

11032

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines Convalescent Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>617 Colorado Avenue 10</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pauline Dorothea Plome</u>		4. DATE OF DEATH <u>Oct. 8, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Registered Nurse</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George S. Plome</u> 14. MOTHER'S MAIDEN NAME <u>Pauline Stauff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>Miss Ann O. Blome 617 Colorado Ave. Balto. 10</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>423</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <u>Sept. 29, 1961, to Oct. 8, 1961</u>, that (I) (we) last saw the deceased alive on <u>Oct. 7, 1961</u>, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Wilmer K. Gallagher</u> M.D. 22b. DATE SIGNED <u>10/9/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> 22d. ADDRESS <u>6209 Frederick Ave. Balt. 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/11/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Tinkins</u>		25a. REC'D BY REGISTRAR <u>OCT 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11043

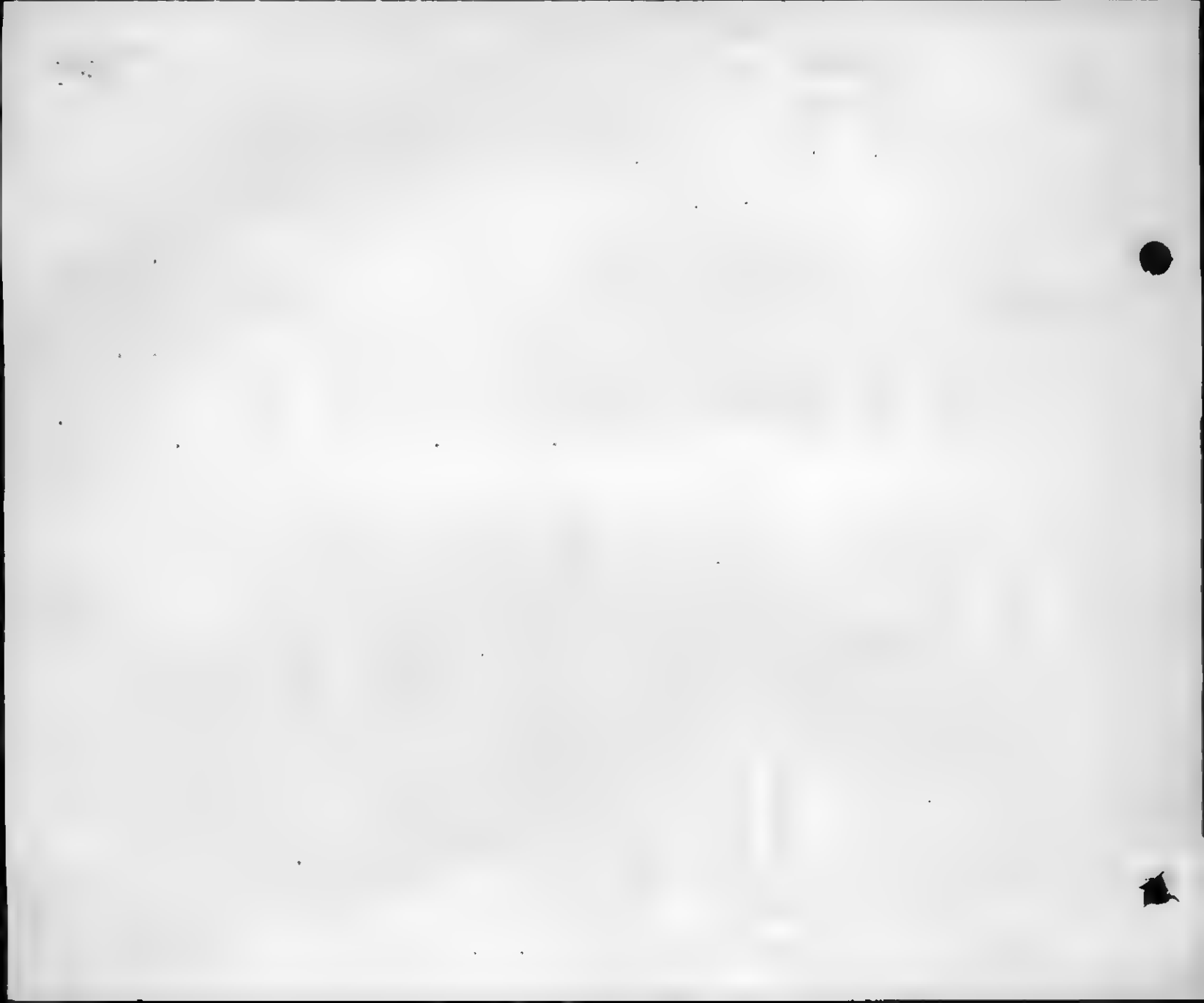
11033

1 PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 47 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westchester Avenue				d. STREET ADDRESS Westchester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Christ ina Agnes Blum		4. DATE OF DEATH Month Day Year Oct. 24, 1961					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1880	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Thomey			14. MOTHER'S MAIDEN NAME Elizabeth Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address City, Md. Mr. Lester H. Blum Westchester Ave. Ellicott			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Oct 10</u> 19 <u>60</u> to <u>Oct 24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 23</u> 19 <u>61</u> , and that death occurred <u>3 P</u> .M. from the causes and on the date stated above.							
22a. SIGNATURE <u>William F. Cassaway</u>				22b. DATE 10/24/61		22c. PHYSICIAN'S NAME (Type) William F. Cassaway	
22d. ADDRESS Ellicott City, Md.				22e. ADDRESS Ellicott City, Md.		22f. ADDRESS Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/1961		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Funeral Home</u>				25a. REC'D BY REGISTRAR DATE OCT 27 61		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

1392

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



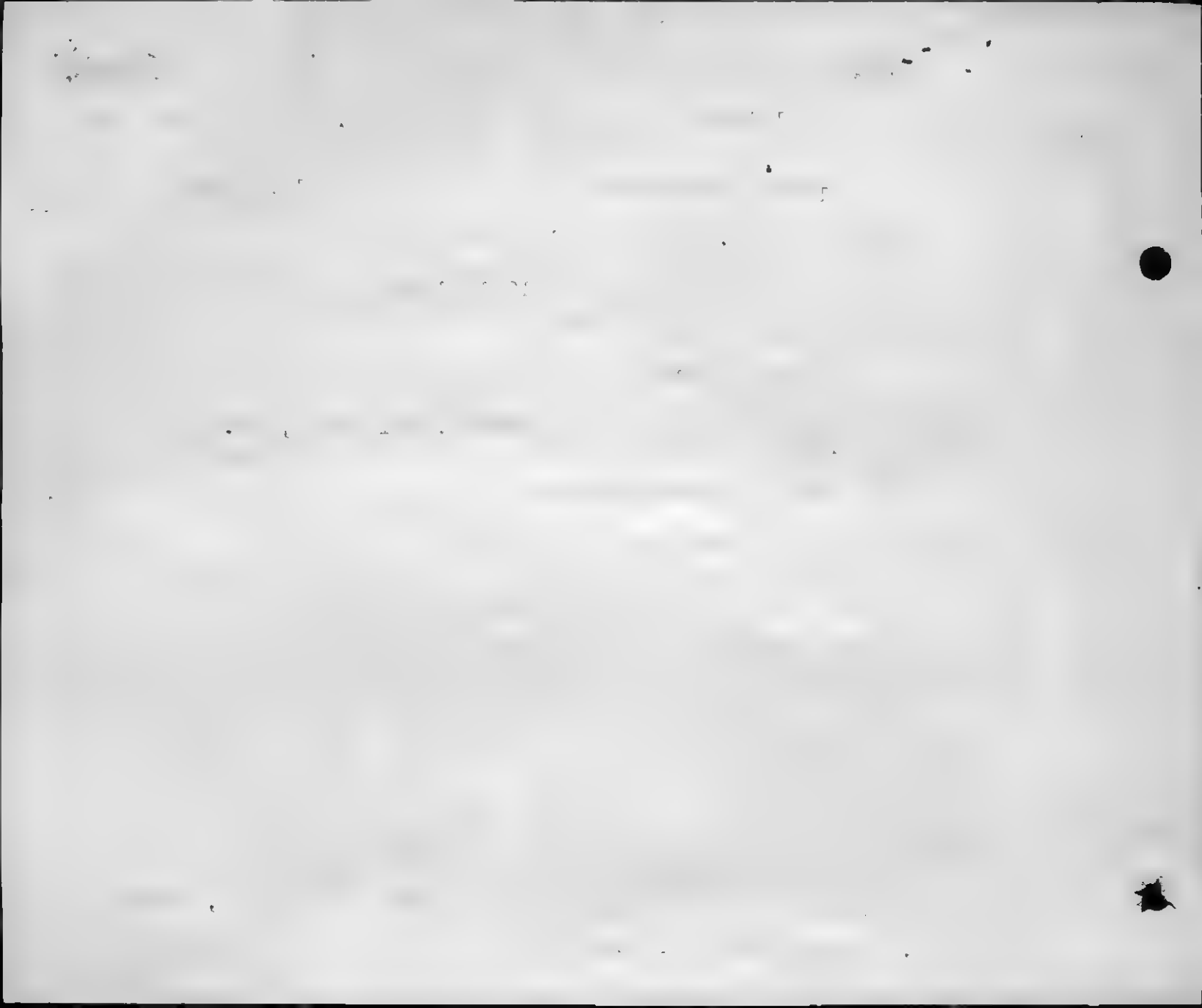
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
11044		Balt. Baltimore		3 hrs.		Md.		Baltimore		11034	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM?		YES		NO		X	
8616 Dovedale Road		4409 Alan Drive									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Maude		L.		Bollinger		BOLLINGER		Oct		27 1961	
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED		DIVORCED		12/15/1898		62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife		Own home		Balt. City		- U.S.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Emmett Loand		Augusta Chambers		none		none		James W. Bollinger, Jr.		8616 Dovedale	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH		10 min.	
		DUE TO		(b)		Hypertensive C.V. Disease				1 yr. +	
		DUE TO		(c)							
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Obesity							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
				Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
				Hour a.m. p.m.							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		D.D. Caples		M.D.						10-27-61	
EXAMINER'S NAME (Type)		D.D. CAPLES		Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
Burial		10/31/61		New Cathedral Cemetery		Baltimore, Maryland					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Howard H. Hubbard		4107 Wilkens Avenue		DATE		OCT 31 '61		Arthur S. Thomas			



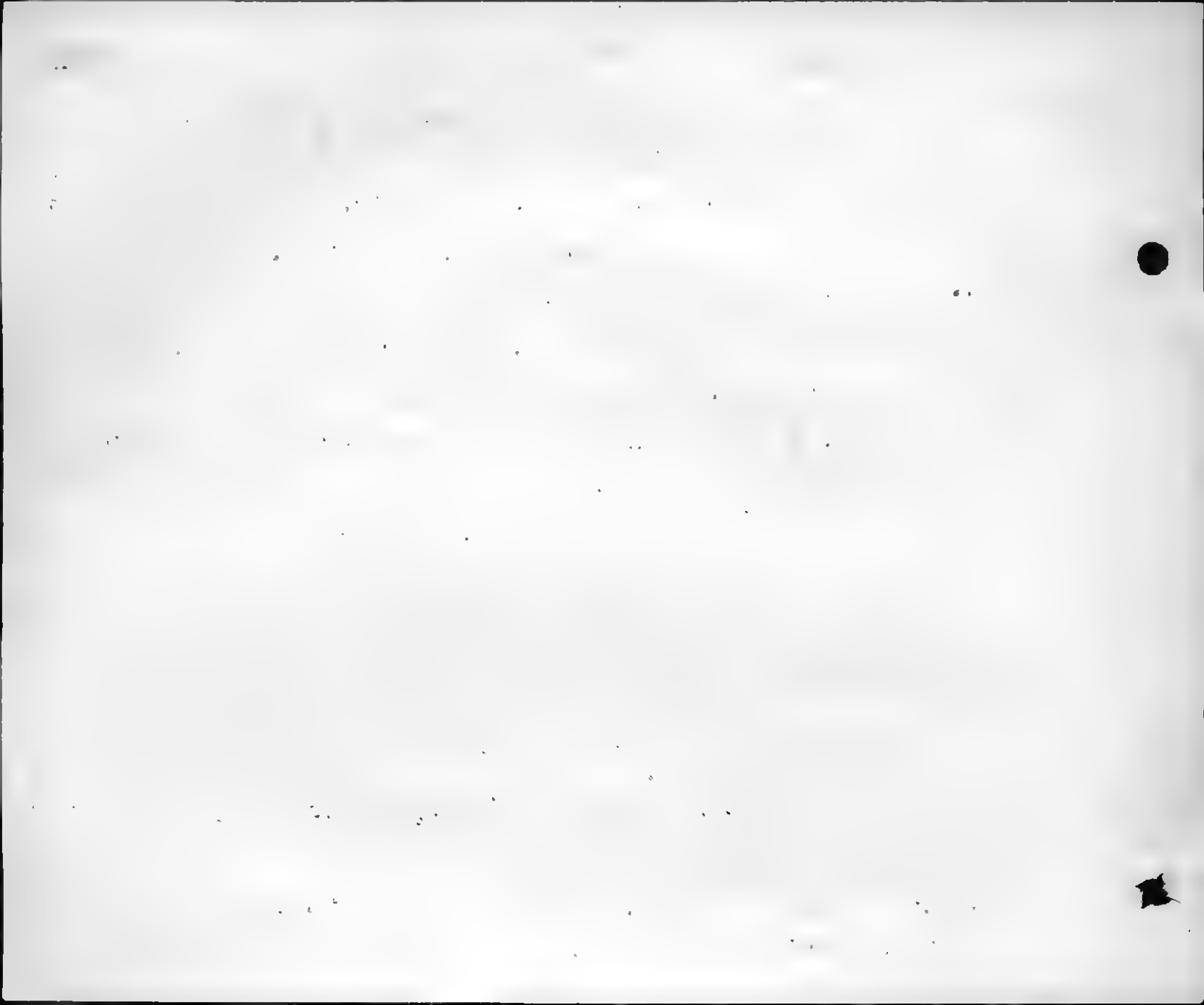
CERTIFICATE OF DEATH

Reg. Dist. No. **11035**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle DAVID Last Bottom JR.		4. DATE OF DEATH Month Oct. Day 13 , Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1916
9. AGE (In years last birthday) yrs. 45		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY National Can Co. Cristfield, Md	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel D. Bottom Sr.		14. MOTHER'S MAIDEN NAME Eva Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 215-09-6044	
17. INFORMANT Betty Shunk Bottom		Address 3805 Cedar Dr. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion X DUE TO Multiple Sclerosis - severe Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1, 1955 to OCT 13, 1961 , that I last saw the deceased alive on OCT 13, 1961 , and that death occurred at 9 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas E. Wheeler M.D. Randallstown Md 10/13/61 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) THOMAS E. WHEELER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-16-61	
22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank M. Newell		ADDRESS Pikesville, Md.	
24a. REC'D BY REGISTRAR DATE OCT 16 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



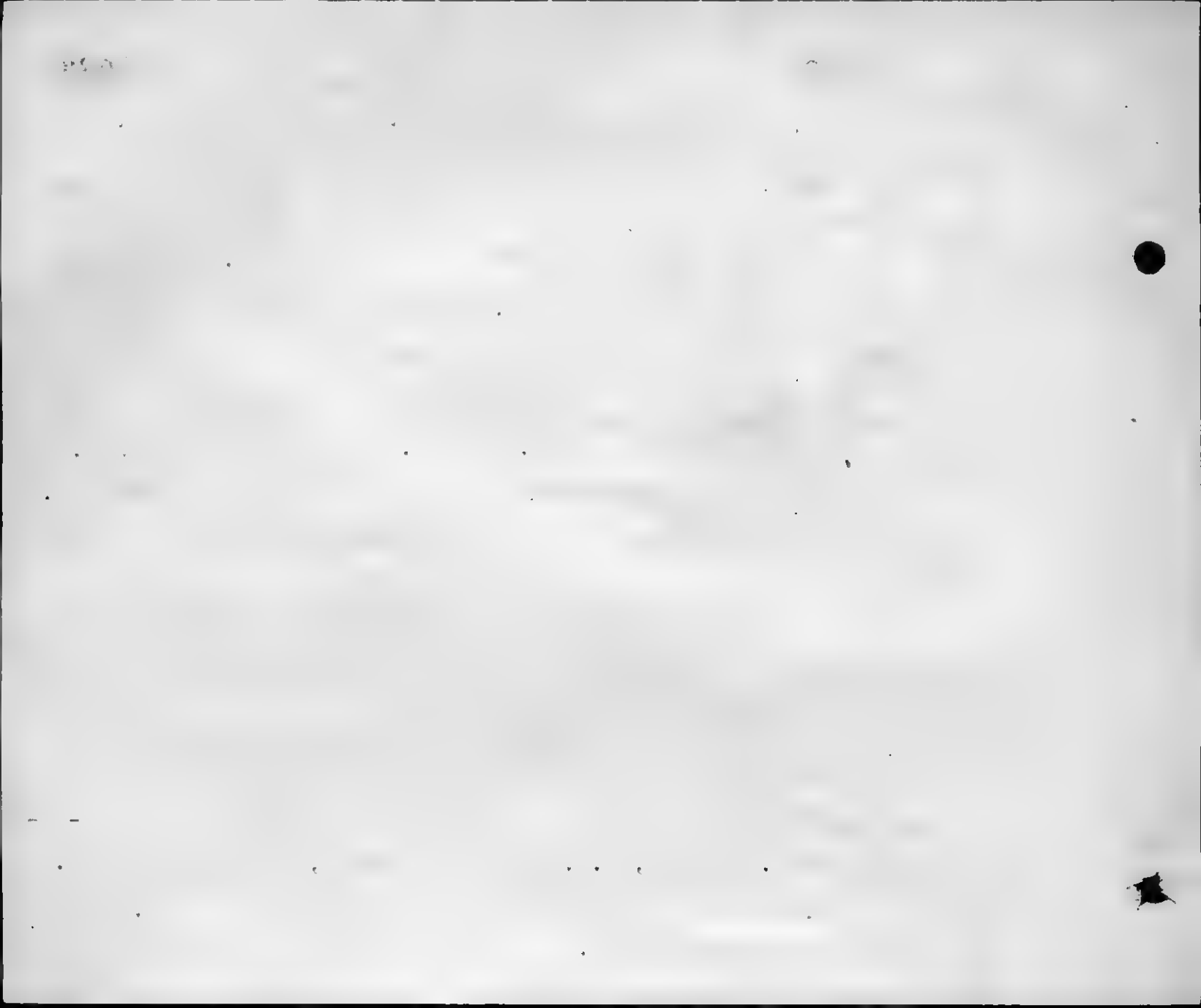
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11046 CERTIFICATE OF DEATH 11036

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>149 Westminster Road</u>		d. STREET ADDRESS <u>149 Westminster Road</u>	
3. NAME OF DECEASED (Type or print) <u>Birdie</u> <u>Louise</u> <u>Broadfoot</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles King</u>		14. MOTHER'S MAIDEN NAME <u>Susannah Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Louise B. Chaney</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u> </u> years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1, 1952</u> to <u>October 23, 1961</u> that (I) (we) last saw the deceased alive on <u>October 20, 1961</u> , and that death occurred at <u>11A</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED <u>10-23-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d. ADDRESS <u>48 Main Street, Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 26, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>OCT 25 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

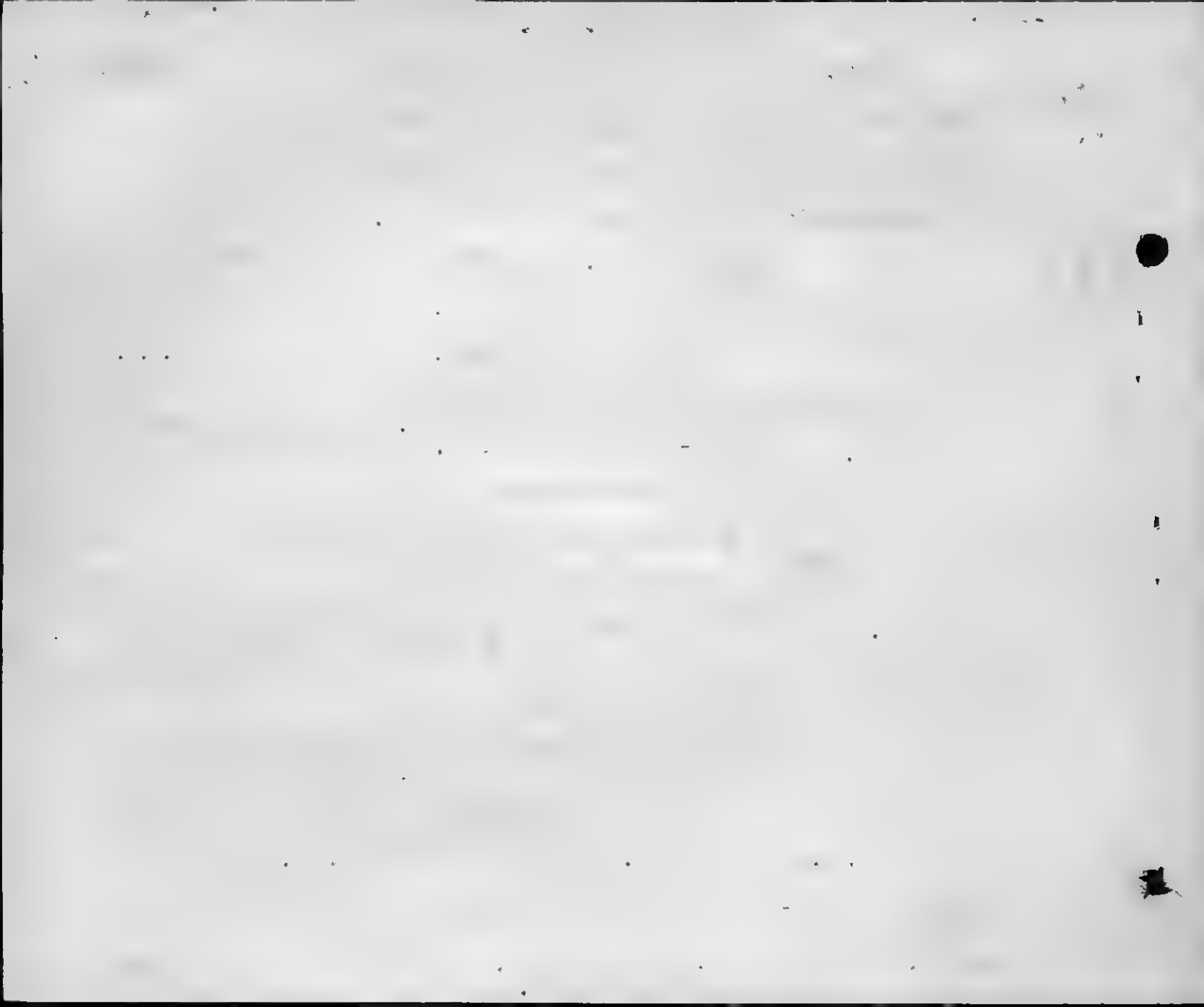
CERTIFICATE OF DEATH

11047

11037

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1349 W. North Avenue</u> d. STREET ADDRESS <u>1349 W. North Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HUBERT A. BROOKS</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>October 10 19 61</u> 8. DATE OF BIRTH <u>November 4, 1900</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Photography</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Ocala, Florida</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Anderson Brooks</u> 14. MOTHER'S MAIDEN NAME <u>Violet Reed</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI</u> 16. SOCIAL SECURITY NO. <u>267-38-8788</u> 17. INFORMANT <u>Clin. Records, VA Hospital Balto 18, Md. Fort Howard Division</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CYSTITIS. CHRONIC PYELONEPHRITIS WITH UREMIA</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19 61</u> Hour a.m. <u> </u> p.m. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <u>HD</u> (this hospital) attended the deceased from <u>OCTOBER 8, 1961</u> to <u>OCTOBER 10, 1961</u> that <u>11</u> (we) last saw the deceased alive on <u>October 10, 1961</u> , and that death occurred <u>11:55AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>F. S. Donaldson</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 10/10/61 22c. PHYSICIAN'S NAME (Type) <u>F. S. DONALDSON, M.D.</u> 22d. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10-16-61</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> Charles R. Law Funeral Home, 802 Madison Ave., Baltimore, Md.		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u> ADDRESS <u>BALTIMORE 28, MARYLAND</u> 25a. REC'D BY REGISTRAR <u>Oct 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

11048

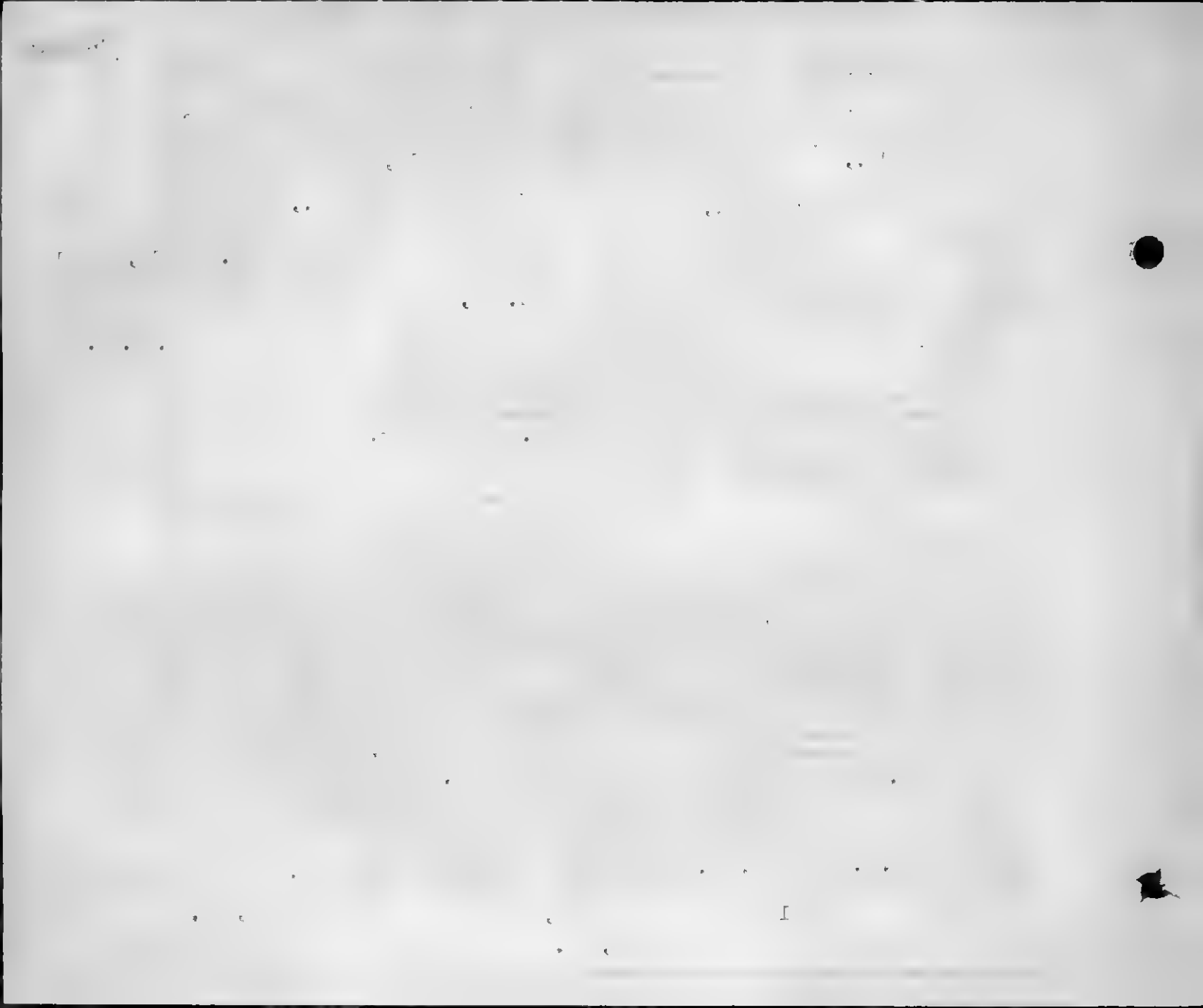
11038

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville., c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 A Winters Lane.,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville., d. STREET ADDRESS 104 A Winters Lane., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle BROWN Last BROWN		4. DATE OF DEATH Month OCT. Day 19, Year 1961	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaih Brown		14. MOTHER'S MAIDEN NAME Laura Nugent	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Sadie Brown: Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (Intestinal) I yr 4 Months 4 Days 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease 19. WAS AUTOPSY PERFORMED? * YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 17th, 1960, to Oct. 19th, 1961 , that I last saw the deceased alive on Oct. 19th, 1961 , and that death occurred at 2.00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane Catonsville, Md. DATE SIGNED 10/19/61 ACTUAL SIGNATURE C.F. Maloney M.D. PHYSICIAN'S NAME (Type) C.F. Maloney, M.D. Catonsville, 28. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/61	
22c. NAME OF CEMETERY OR CREMATORY Western Star,		22d. LOCATION (City, town, or county) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden, ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR OCT 24 '61 24b. REGISTRAR'S SIGNATURE William S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11049

11039

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7(Rockdale)		c. LENGTH OF STAY IN 1b. 7 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7(Rockdale)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3662 Clifmar Road				d. STREET ADDRESS 3662 Clifmar Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sia Middle Paul Last Brown				4. DATE OF DEATH Month October Day 23 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1909		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY General Baking Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Brown				14. MOTHER'S MAIDEN NAME Cecelia Combs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-3588		17. INFORMANT Mrs. Ellen C. Brown, 3662 Clifmar Road, Baltimore 7, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR STAND STILL 120.1 DUE TO COMPLETE HEART BLOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from JANUARY, 1961 , to OCTOBER, 1961 , that (I) (we) last saw the deceased alive on OCTOBER 23, 1961 , and that death occurred at 1206 , from the causes and on the date stated above							
22a. SIGNATURE Samuel P. Scalia				22b. DATE SIGNED 10-25-61		22c. PHYSICIAN'S NAME (Type) Dr. Samuel P. Scalia	
22d. ADDRESS 1331 Reisterstown Rd, Pikesville 8, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) Baltimore (State) Maryland	
24a. FUNERAL DIRECTOR'S SIGNATURE Lesing Byers		24b. ADDRESS 8728 Liberty Road Randallstown, Md.		25a. REC'D BY REGISTRAR OCT 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO TOTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11050

CERTIFICATE OF DEATH

11040

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
c. LENGTH OF STAY IN 1b <u>2 mos</u>		3. STREET ADDRESS <u>Prettyboy Dam Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prettyboy Dam Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stanley Guy Brown</u>		DATE OF DEATH <u>October 4 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30/1898</u>
9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George B. Brown</u>	14. MOTHER'S MAIDEN NAME <u>Grace Keene</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>	16. SOCIAL SECURITY NO. <u>213-013217</u>	17. INFORMANT <u>Mrs. Mildred Brown, Parkton, Md. R.D.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>Oct. 4 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 3 1961</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10/6/61</u>
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 7-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>	23d. LOCATION (City, town or county) <u>Parkton, Md.</u> (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>Oct 10 '61</u>	25b. REGISTRAR'S SIGNATURE <u>William L. Houser</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

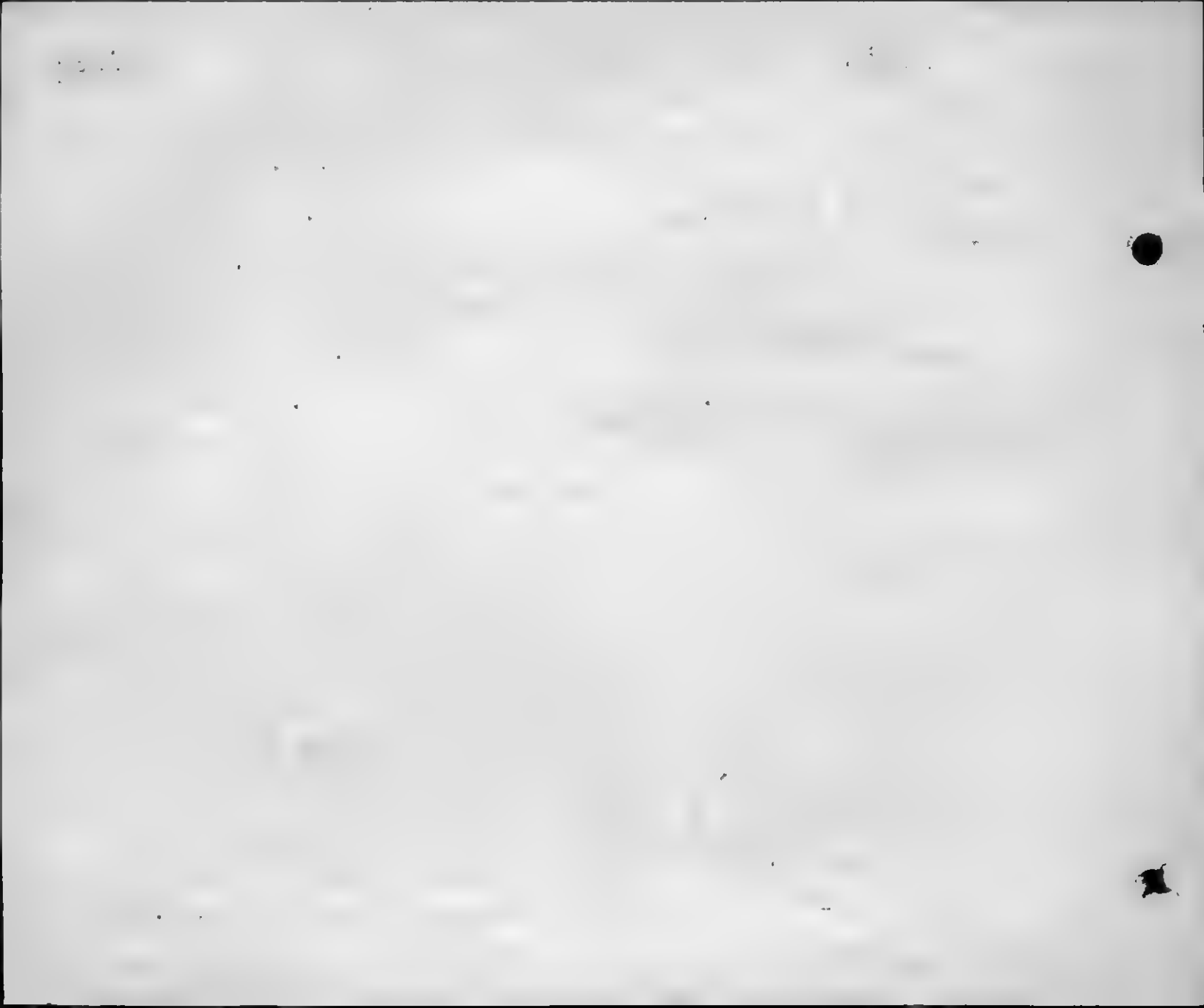
11051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11041

<p>1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY in lb 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Md. d. STREET ADDRESS 518 Franklin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) Hughes England Burlin</p>				<p>4. DATE OF DEATH Oct. 20 19 61</p>			
<p>5. SEX M</p>		<p>6. COLOR OR RACE W</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 1879</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Laborer</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Day</p>		<p>11. BIRTHPLACE (State or foreign country) Unknown Md.</p>		<p>12. CITIZEN OF WHAT COUNTRY? Unknown/U.S.A.</p>	
<p>13. FATHER'S NAME Unknown/ Samuel O. Burlin</p>				<p>14. MOTHER'S MAIDEN NAME Unknown Mary A. Carroll</p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give year or dates of service) No Unknown</p>				<p>17. INFORMANT Records: Spring Grove State Hospital</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO (b) Intestinal Malignancy (Carcinoma) DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 153.9</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE George M. Kieffer EXAMINER'S NAME (Type) George M. Kieffer, M. D.</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1010 Lead... Address (Street, city, town, or county) 10/20/61</p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF 10-23-1961</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery</p>		<p>22d. LOCATION (City, town, or country) (State) Port Deposit, Md. Rural</p>	
<p>23. FUNERAL DIRECTOR See Ad. Kieffer & Son, Parynville, Md.</p>				<p>24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 10/23/61</p>			

MEDICAL CERTIFICATION

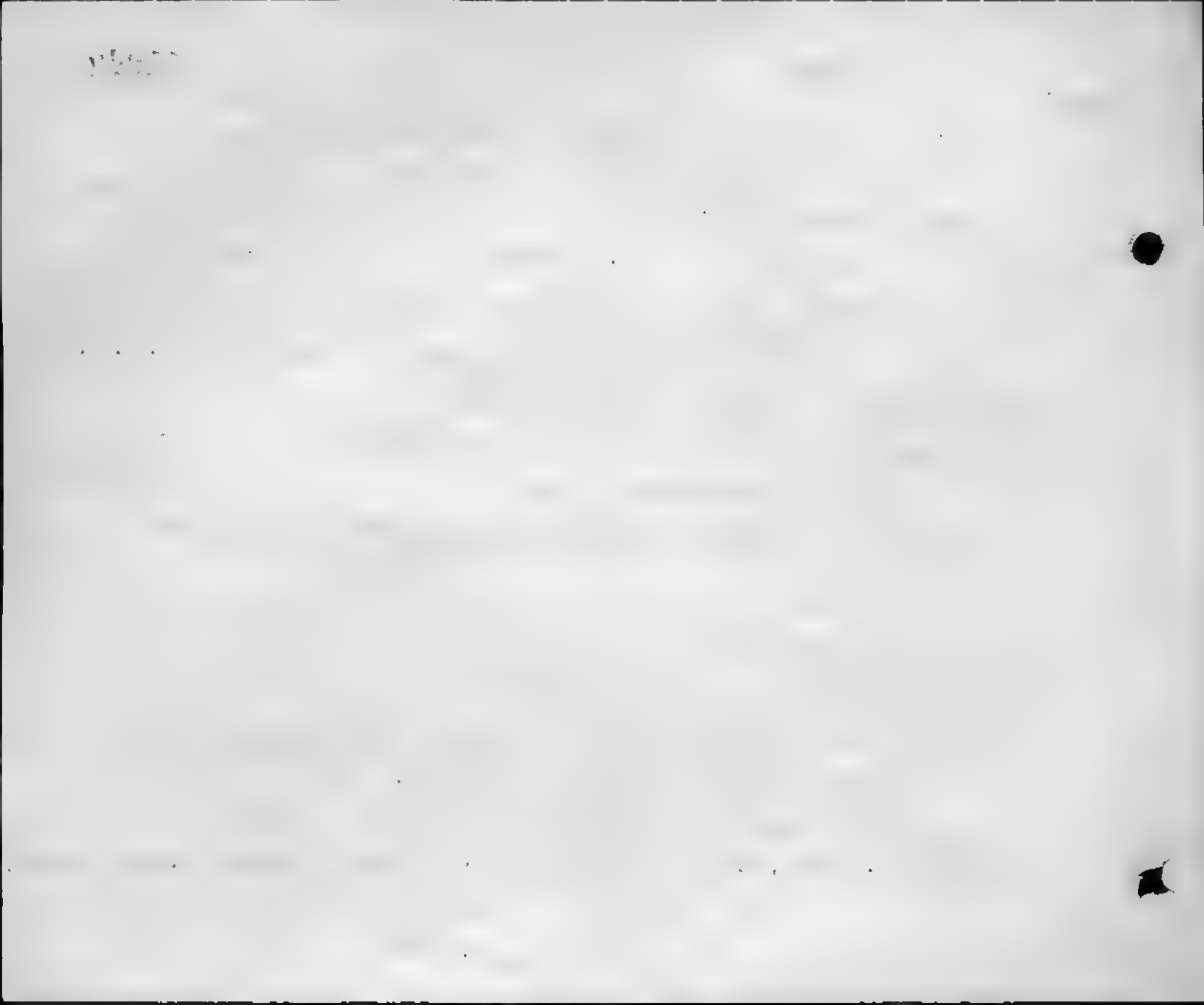


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
11052
11042
M
I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b. 7 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge g. STREET ADDRESS 1411 Montgomery Road h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUTHER F. BUTTS		4. DATE OF DEATH Month Day Year October 11 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1930
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months Days 11 135	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Houses	
11. BIRTHPLACE (County & State, or foreign country) McGehee, Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Butts		14. MOTHER'S MAIDEN NAME Lillie McKenny	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 429-52-0962	
17. INFORMANT Clinical Records VAH, Baltimore 18, Maryland		18. FORT HOWARD DIVISION	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL BLEEDING DUE TO Conditions, if any, which gave rise to immediate cause (b) ANEURISM OF INTERNAL CAROTID ARTERY, LEFT, CONGENITAL (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 4, 1961 to October 11, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 11, 1961 , and that death occurred at 11:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 10/12/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home		25a. REC'D BY REGISTRAR 3331 Abrams Lane 2601 E. Madison, Balto. DATE OCT 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

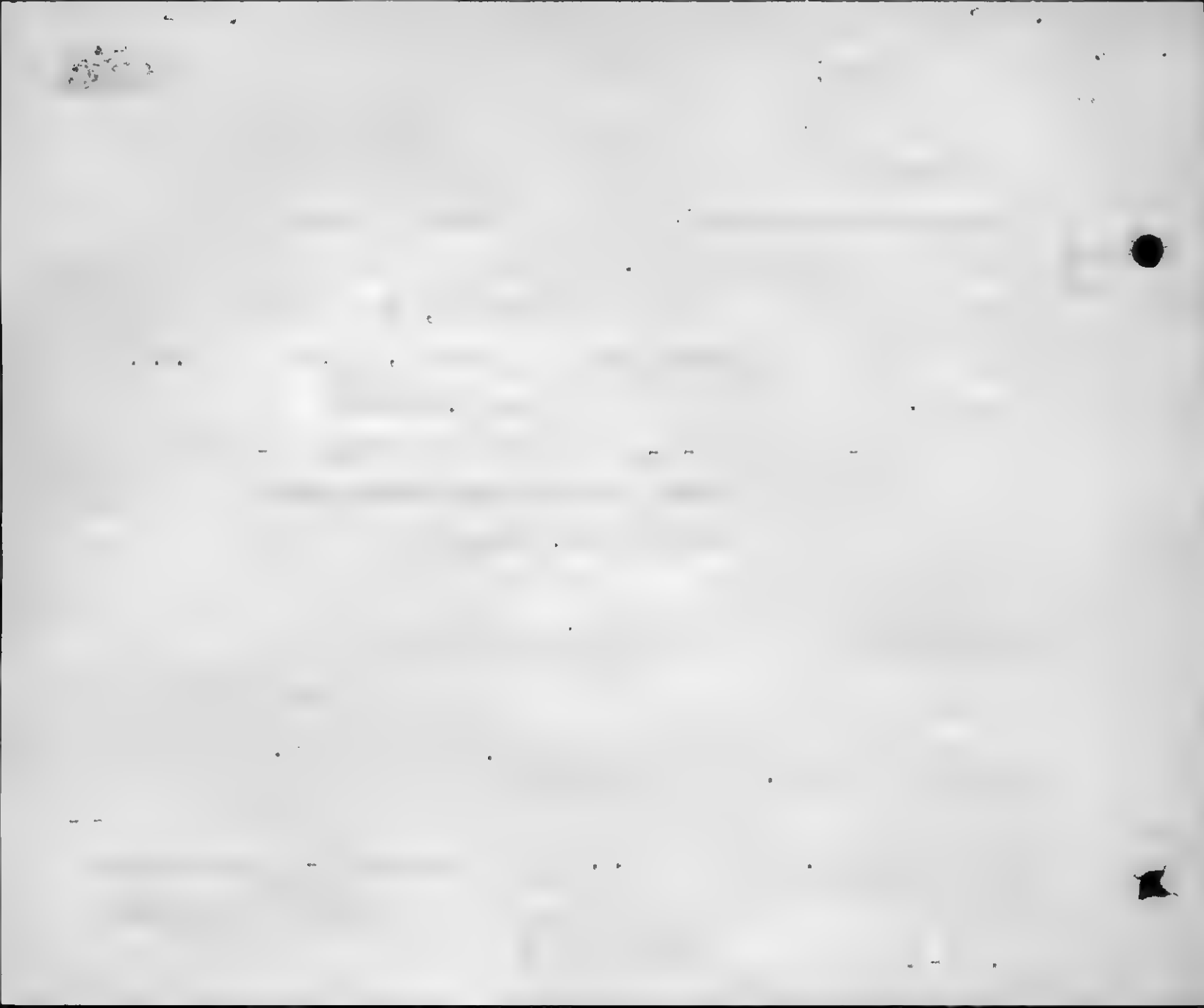
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11053

11043

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 705 Westover Road	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT O. BUTTS		4. DATE OF DEATH October 5 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH February 1, 1894		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wine Steward		10b. KIND OF BUSINESS OR INDUSTRY Club	
11. BIRTHPLACE (Country & State, or foreign country) Baltimore Country/ Woodstock, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur U. Butts		14. MOTHER'S MAIDEN NAME Mary E. Everhart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1		16. SOCIAL SECURITY NO. 218-03-5332	
17. INFORMANT Clin Rec VAH Baltimore Md-Ft Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY			
DUE TO (b) ARTERIOSCLEROSIS, GENERAL			
DUE TO (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema of Lungs; Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 29 19 61 to Oct. 5 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 5 19 61 , and that death occurred at 3:35 P M , from the causes and on the date stated above.			
22a. SIGNATURE John W. Pemberton M.D.			
22b. DATE SIGNED 10-5-61			
22c. PHYSICIAN'S NAME (Type) John W. Pemberton M.D. VAH Baltimore Md - Ft Howard Division			
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 10-9-61			
23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
23d. LOCATION (City, town or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc			
25a. REC'D BY REGISTRAR Oct 10 '61			
25b. REGISTRAR'S SIGNATURE Charles L. Hume			



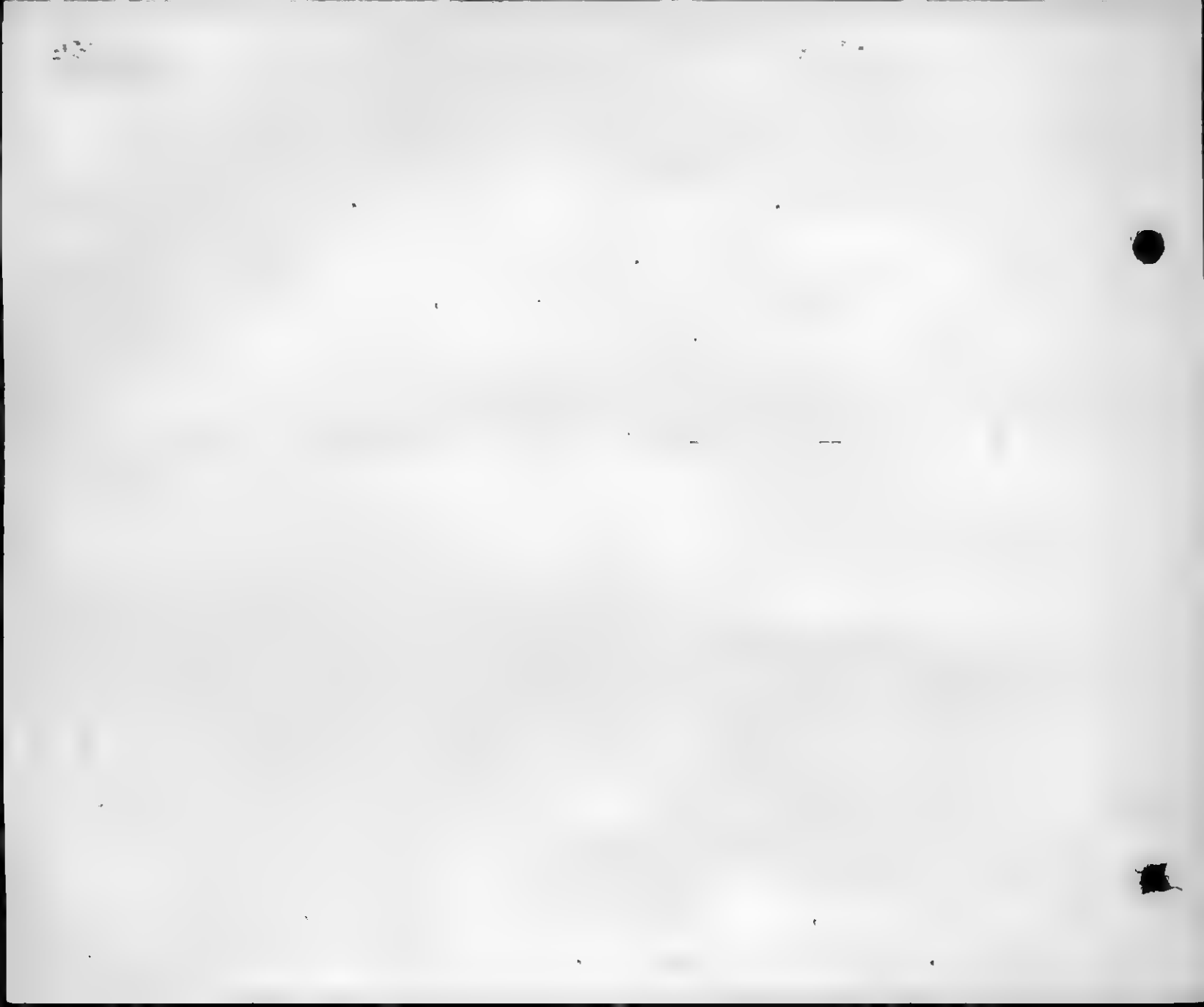
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11054

11044

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1713 Ann Ave.				d. STREET ADDRESS 1713 Ann Ave.			
3. NAME OF DECEASED (Type or print) First Guy Alton Middle Calligan Last Sr.				4. DATE OF DEATH Month October Day 29 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1894	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Calligan				14. MOTHER'S MAIDEN NAME Mary Elizabeth Abbott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2570		17. INFORMANT Anna Elizabeth Calligan Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Cancer of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/15/61 to 10/29/61 19 61 that (I) we lost saw the deceased alive on 10/29 19 61 , and that death occurred on 10/29 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Lyden				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/30/61	
22c. PHYSICIAN'S NAME (Type) ROBERT J. LYDEN				22d. ADDRESS 815 EASTERN AVE BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/61		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		23d. LOCATION (City, town, or county) (State) Belair, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski				ADDRESS 1407 Eastern Ave.		25a. REC'D BY REGISTRAR OCT 31 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11045

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u> </u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>361 EITENMILLER RD - BALT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u> </u>		d. STREET ADDRESS <u>4316 BELAIR RD - 6</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EDWARD</u> Last <u>CHARLTON</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 26 - 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Mins <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEERING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES CHARLTON</u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT Address <u>BALTO 7-MD</u> <u>MRS DOLORES SCHLIPPER - 3621 EITENMILLER RD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertensive C.V. disease & renal insufficiency.</u>		(c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 1</u> , 19 <u>61</u> , to <u>OCT 18</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>OCT 18</u> , 19 <u>61</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D.		ADDRESS (Street, city or town, state) <u>Randallstown - Md</u> DATE SIGNED <u>10-18-61</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>		22a. REC'D BY REGISTRAR DATE <u>OCT 20 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/21/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME</u> ADDRESS <u>4220 BELAIR RD</u>		24b. REGISTRAR'S SIGNATURE <u>Carling S. Kenna</u>	



11055
11047
CERTIFICATE OF DEATH
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTO.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTO. 21</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>IVY HALL NURSING HOME</i>		d. STREET ADDRESS <i>1011 ARN CLIFF RD.</i>	
3. NAME OF DECEASED (Type or print) <i>Helen E. Church</i>		4. DATE OF DEATH <i>Oct 23 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 21, 1886</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>RUMANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>RAUSCH</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>HENRY F. BECKER</i>		Address <i>8628 OAKLEIGH RD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Apoplexy</i> DUE TO <i>Hypertension and arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 15, 1959</i> to <i>Oct 23, 1961</i> that I last saw the deceased alive on <i>Oct 23, 1961</i> and that death occurred at <i>5:30 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry F. Becker</i>		ADDRESS (Street, city or town, state) <i>901 Fuselage Dr Baltimore 20 Md</i> DATE SIGNED <i>Oct 23, 61</i>	
PHYSICIAN'S NAME (Type) <i>IRVING R. BECK M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>10-26-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GARDENS OF FAITH</i>	22d. LOCATION (City, town, or county) (State) <i>BALTO. CO. MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.W. JENKINS & Sons Co</i>		ADDRESS <i>4905 YORK ROAD</i>	
24a. REC'D BY REGISTRAR <i>Oct 25, 61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

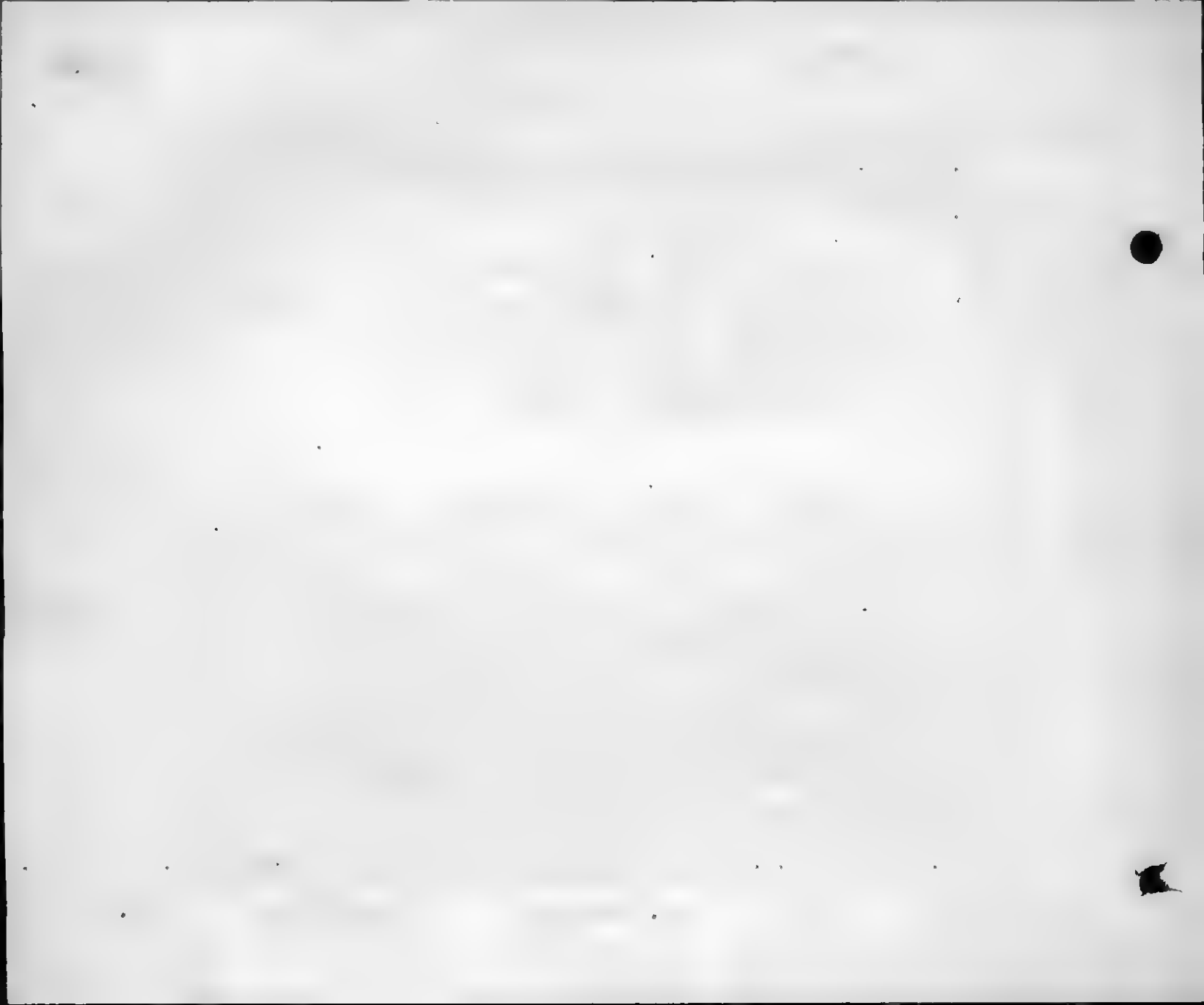
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11057											
11047											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN TB 32 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30 d. STREET ADDRESS 817 West Ostend Street					
3. NAME OF DECEASED (Type or print; First Middle Last) JOSEPH W. CLARK						4. DATE OF DEATH Month Day Year October 27 1961					
5. SEX Male						6. COLOR OR RACE Negro					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH February 19, 1896					
9. AGE (In years last birthday) 65 yrs.						10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer						10b. KIND OF BUSINESS OR INDUSTRY Public Building					
11. BIRTHPLACE (County & State or foreign country) Max Meadows, Virginia						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Austin Clerk						14. MOTHER'S MAIDEN NAME Allice Grogans					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 216-01-3205					
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASIS TO ABDOMINAL ORGANS DUE TO (b) 151X DUE TO (c) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation-10/3/61 Exploratory Laparotomy, gastroenterostomy											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from September 25, 1961 to October 27, 1961 that (he) (she) (it) (we) last saw the deceased alive on October 27, 1961 and that death occurred at A. M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan						22b. DATE 10/27/61					
22c. PHYSICIAN'S NAME (Type or print) THOMAS F. CRAHAN, M.D.						22d. ADDRESS VAH, BALTO. 18 MD., FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 10/31/61					
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery						23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice						25. REC'D BY REGISTRAR OCT 30 '61					
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

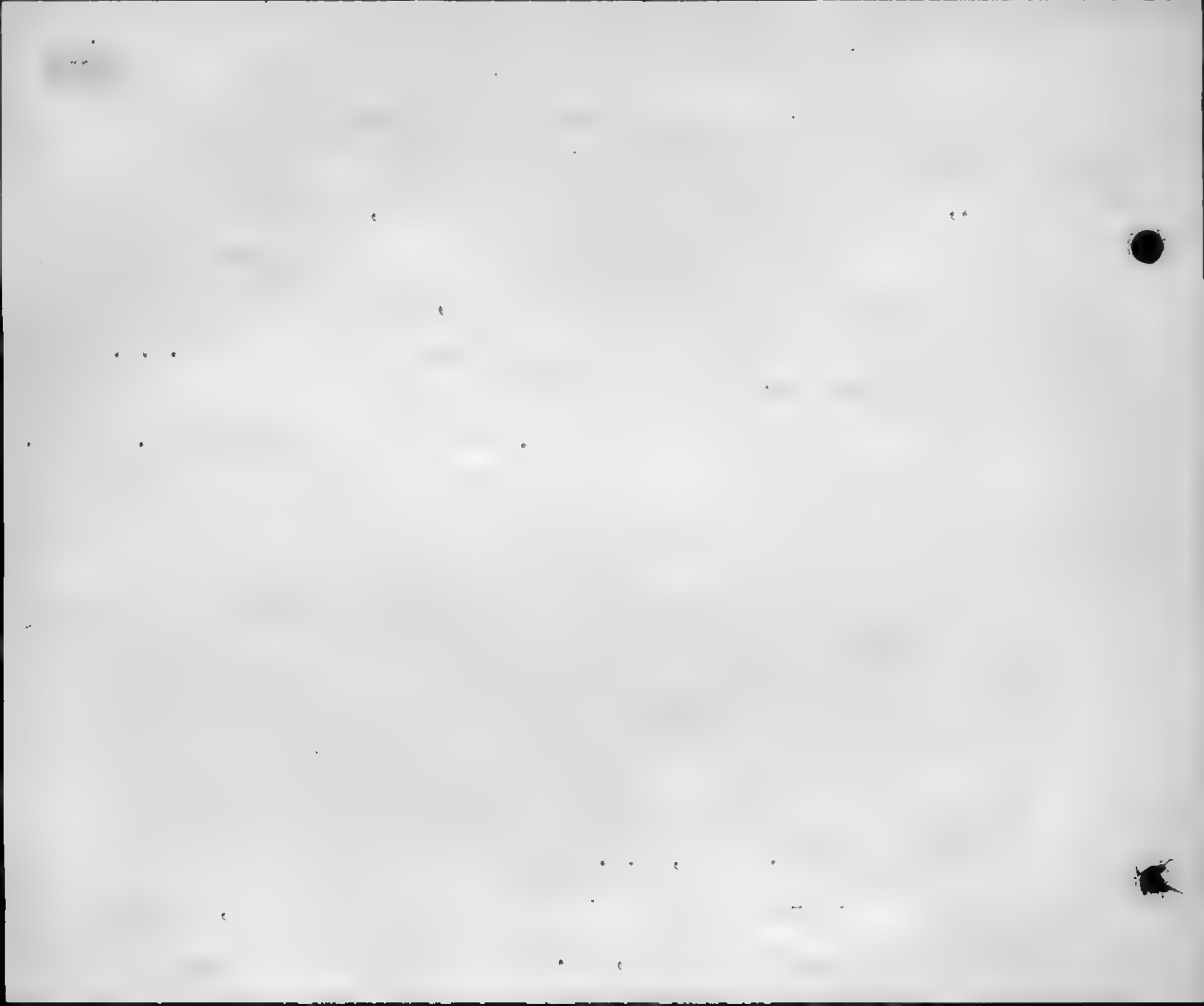
11058
11048
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN 1b <u>13 mo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1800</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>4653 Lacy Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PHILIP KING CLARKE</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10.3.1889</u> 9. AGE (In years lost birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Retired policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PHILIP M. CLARKE</u>		14. MOTHER'S MAIDEN NAME <u>AGNES TUCKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced pulmonary tuberculosis</u> DUE TO <u>leis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus. Uremia</u> DUE TO (c) <u>4 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus. Uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9.30</u> 19 <u>60</u> to <u>10.31</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10.31</u> 19 <u>61</u> , and that death occurred at <u>10:20</u> am the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. Newcomer</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u> 22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>		22b. DATE SIGNED <u>10.31.1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		23d. LOCATION (City, town, or county) (State) <u>Leonardtown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Haltingly</u> ADDRESS <u>Leonardtown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Richard S. Kraus</u>	



DATE OCT 20 '61

Ernst L. Kraus



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

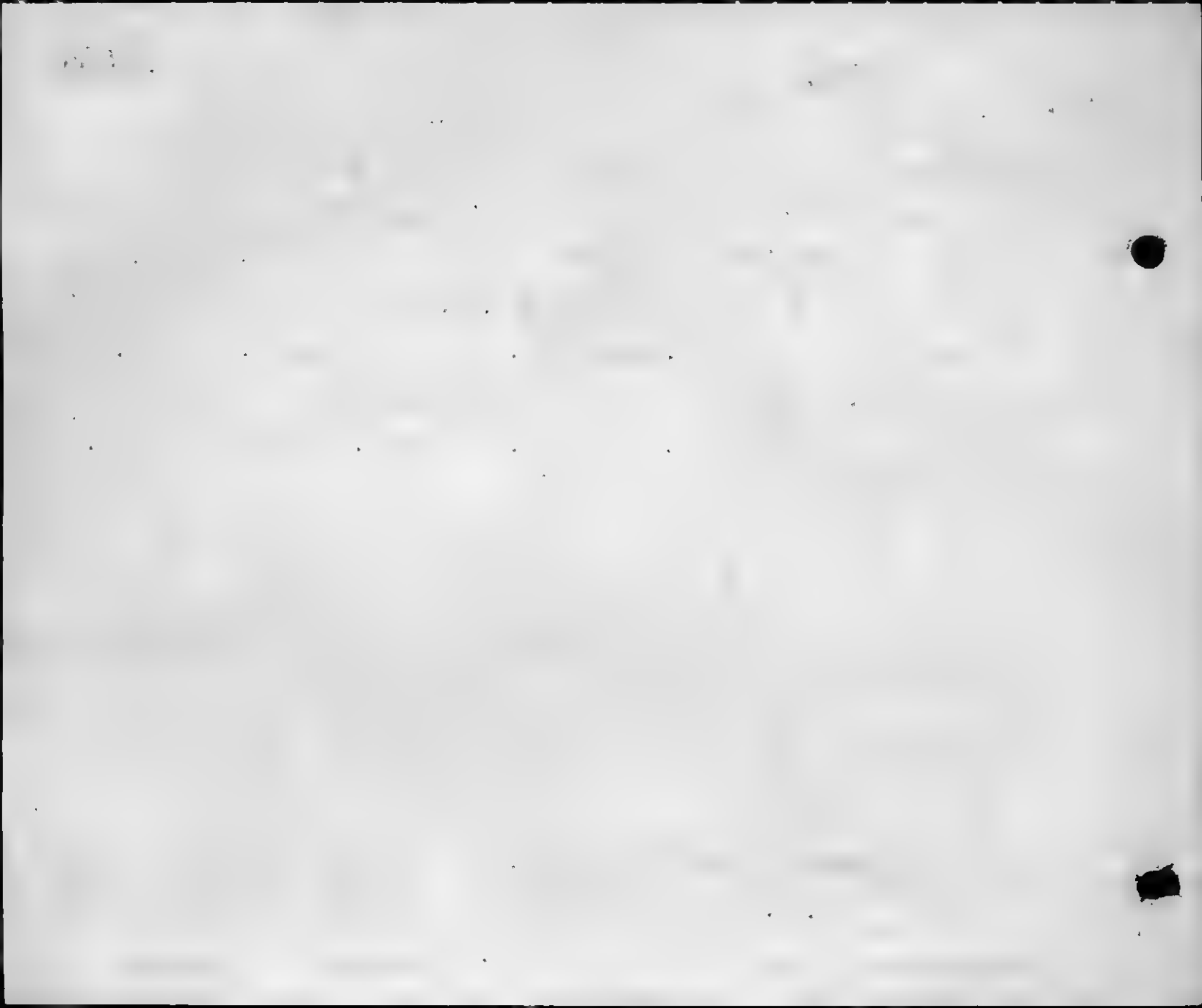
Item #13 Dalm #453

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11060

11050

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN b 26 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 36 Bosley Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 36 Bosley Avenue			
3. NAME OF DECEASED (Type or print) William Marshall Cook				4. DATE OF DEATH Month October Day 22 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1896	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman				10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co. Baltimore City, Md.			
13. FATHER'S NAME Marshall P. Cook				14. MOTHER'S MAIDEN NAME Florence Dove			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No				16. SOCIAL SECURITY NO. 213-05-9023			
17. INFORMANT Mrs. Augusta B. Cook				Address Reisterstown, Md. 36 Bosley Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis + due to DUE TO (b) Congestive Heart Failure - Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Arteriosclerosis - generalized				INTERVAL BETWEEN ONSET AND DEATH Instant 2 years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1953 to October 24, 1961, that (I) (we) last saw the deceased alive on October 15, 1961, and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Clarence E. McWilliams M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED October 23, 1961	
22c. PHYSICIAN'S NAME (Type) Clarence E. McWilliams M.D.				22d. ADDRESS 11904 Reisterstown Rd. Reisterstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		23d. LOCATION (City, town or county) (State) Finksburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry James Eckhardt				25. REC'D BY REGISTRAR October 25 '61			
ADDRESS Owings Mills, Md.				25b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

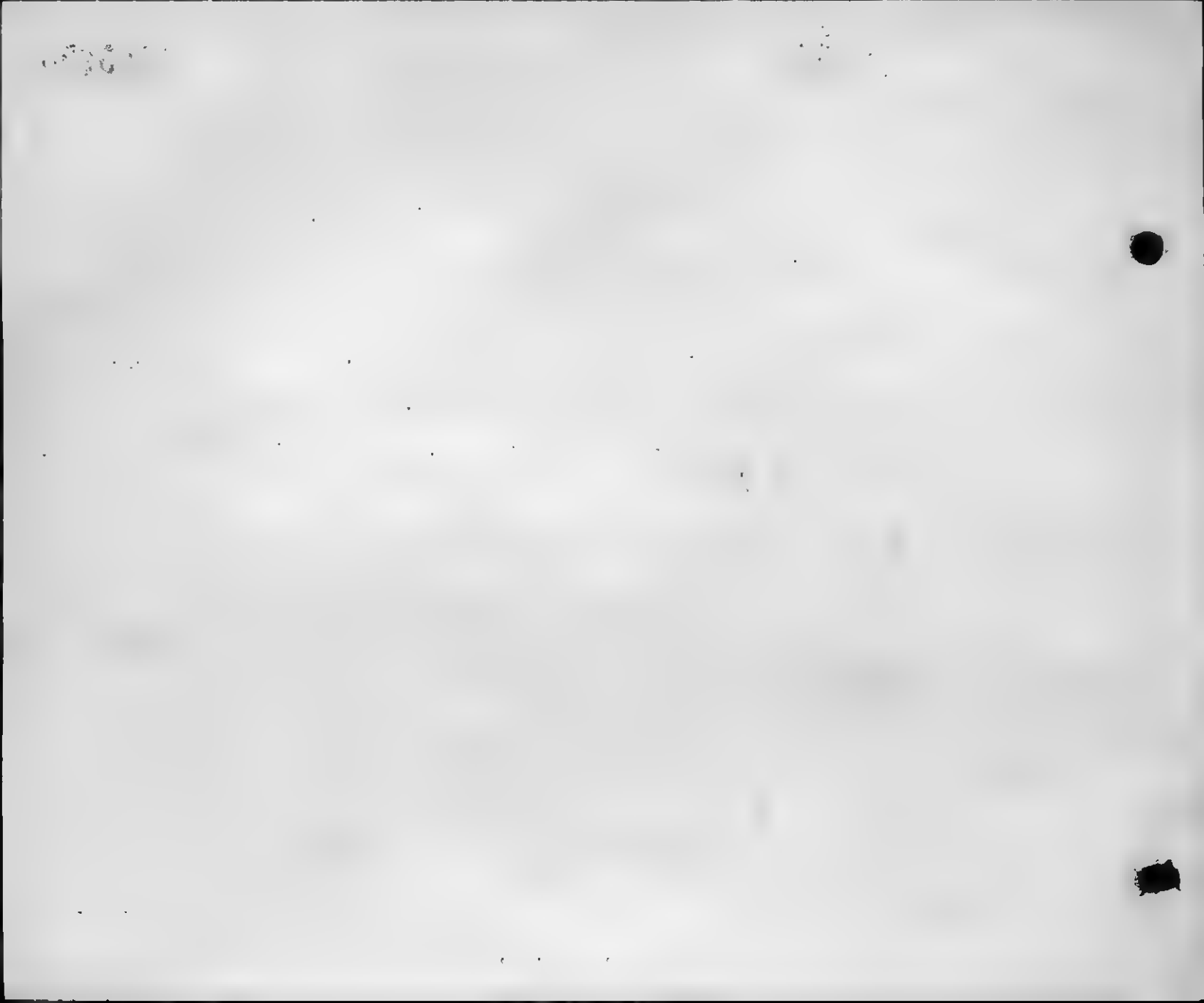
11061

CERTIFICATE OF DEATH

11051

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>(at his residence--1824 Vista Lane)</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> d. STREET ADDRESS <u>1824 Vista Lane.</u>			
3. NAME OF DECEASED (Type or print) <u>William Franklin Crawford</u> First Middle Last				4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July-1-1898</u>			
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Cans</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>CLINTON LEE CRAWFORD</u>			
14. MOTHER'S MAIDEN NAME <u>Minnie M. McMackin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1215-05-2007</u>			
17. INFORMANT <u>Mrs Edith G. Crawford (wife)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>chronic bronchitis</u> (c) <u>502.0</u> DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 1961</u> to <u>Oct 22 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 19 1961</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William F. Fritz</u> M.D.				22b. DATE SIGNED <u>10/25/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>William F. Fritz - MD.</u>				22d. ADDRESS <u>20 University Parkway</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Oct-25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GreenMount</u>			
23d. LOCATION (City, town or county) <u>Baltimore City 2, Md.</u>		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Stewart & Townen Co. 108 North-Av, Balto. 1, Md</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

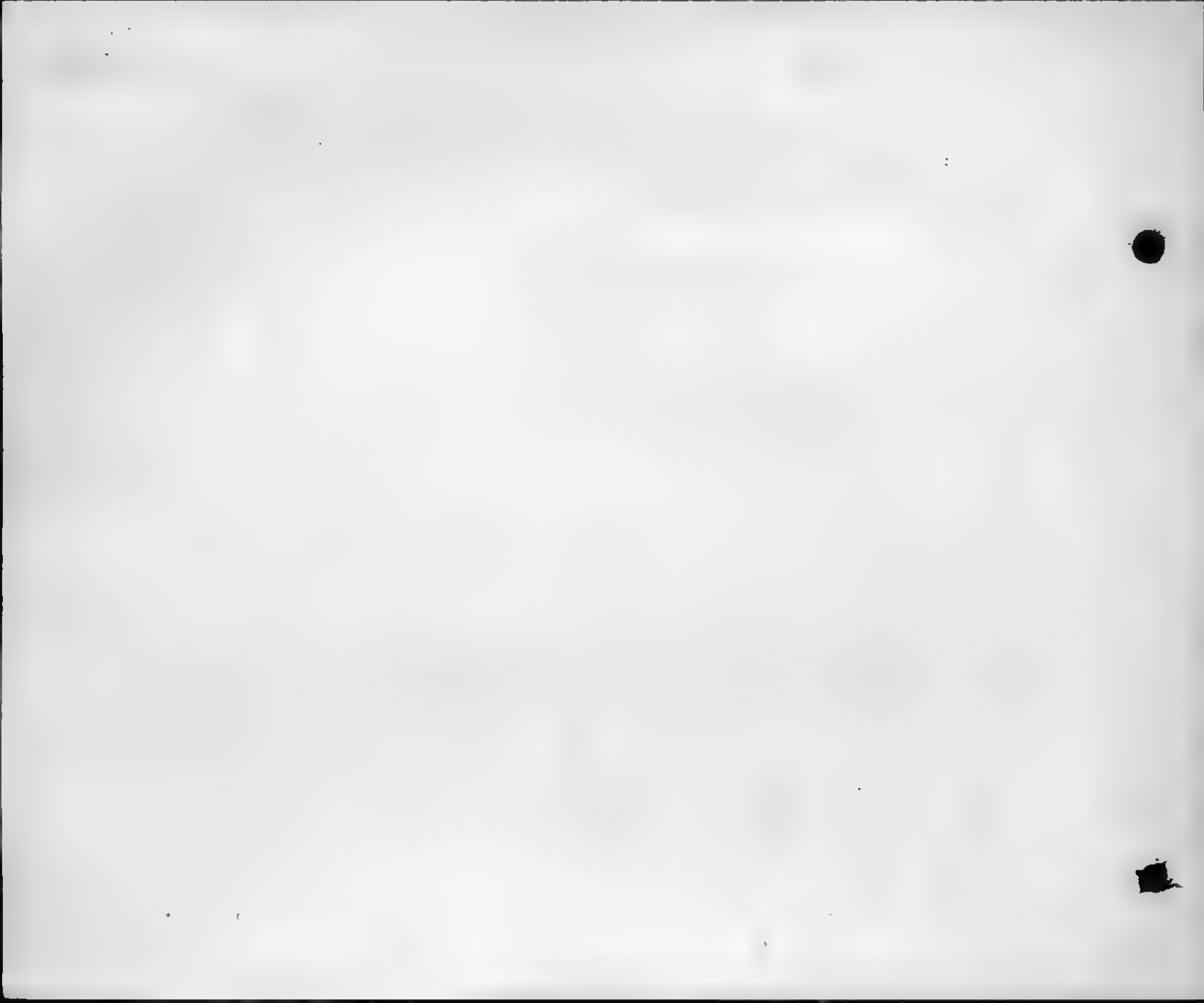
CERTIFICATE OF DEATH

Reg. Dist. No. 11052

11062

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Washington, D.C. c. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 3120 Wisconsin Ave	
3. NAME OF DECEASED (Type or print) First Georgena Middle H. CRENshaw Last CRENSHAW		4. DATE OF DEATH Month 10 Day 20 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1883
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR: Months 7 Days 20 Hours 20 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BUTLER Co. ALA.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George R. UPTON		14. MOTHER'S MAIDEN NAME Isabella Hurlford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 21 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-23 , 19 61 , to 10-29 , 19 61 , that I last saw the deceased alive on 10-29 , 19 61 , and that death occurred at 11:55 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton B. Kline M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10-30-1961	22c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery	22d. LOCATION (City, town, or county) (State) Greenville, Ala.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. ...		24a. REC'D BY REGISTRAR DATE OCT 31 '61	24b. REGISTRAR'S SIGNATURE ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

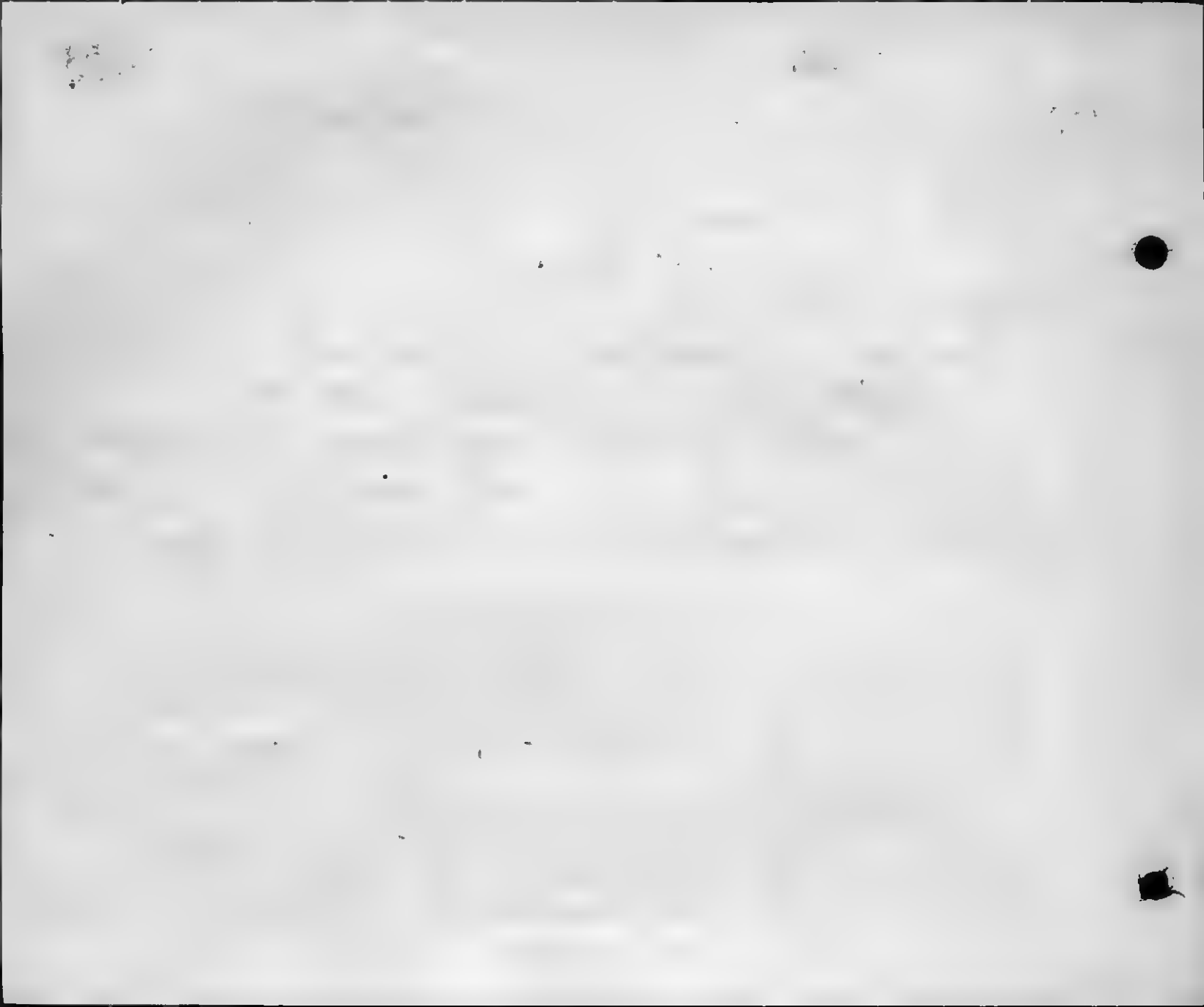
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11063

11053

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>		c. LENGTH OF STAY in 7b <u>60 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8346 Old Philadelphia Rd.</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>	
3. NAME OF DECEASED (Type or print) <u>John Thomas Davis</u>		d. STREET ADDRESS <u>8346 Old Philadelphia Rd.</u>	
5. SEX <u>Male</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1961</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Oct. 12, 1879</u>		9. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Farm.</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Elisha Davis</u>		14. MOTHER'S MAIDEN NAME <u>Annie McQuillan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-5492</u>	
17. INFORMANT <u>Mary Agnes Chisholm</u>		Address <u>8346 Old Philadelphia Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>arteriosclerotic Cardiovascular disease</u> 5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>61</u> , to <u>Oct 12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 12</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>WMB Baumgardner</u> M.D.		22b. DATE SIGNED <u>10/12/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Balto 6 Md.</u>		22d. ADDRESS <u>Balto 6 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-16-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Church Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Czech</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 16 '61</u>	
ADDRESS <u>1211 Cheseco Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Kimes</u>	



11064

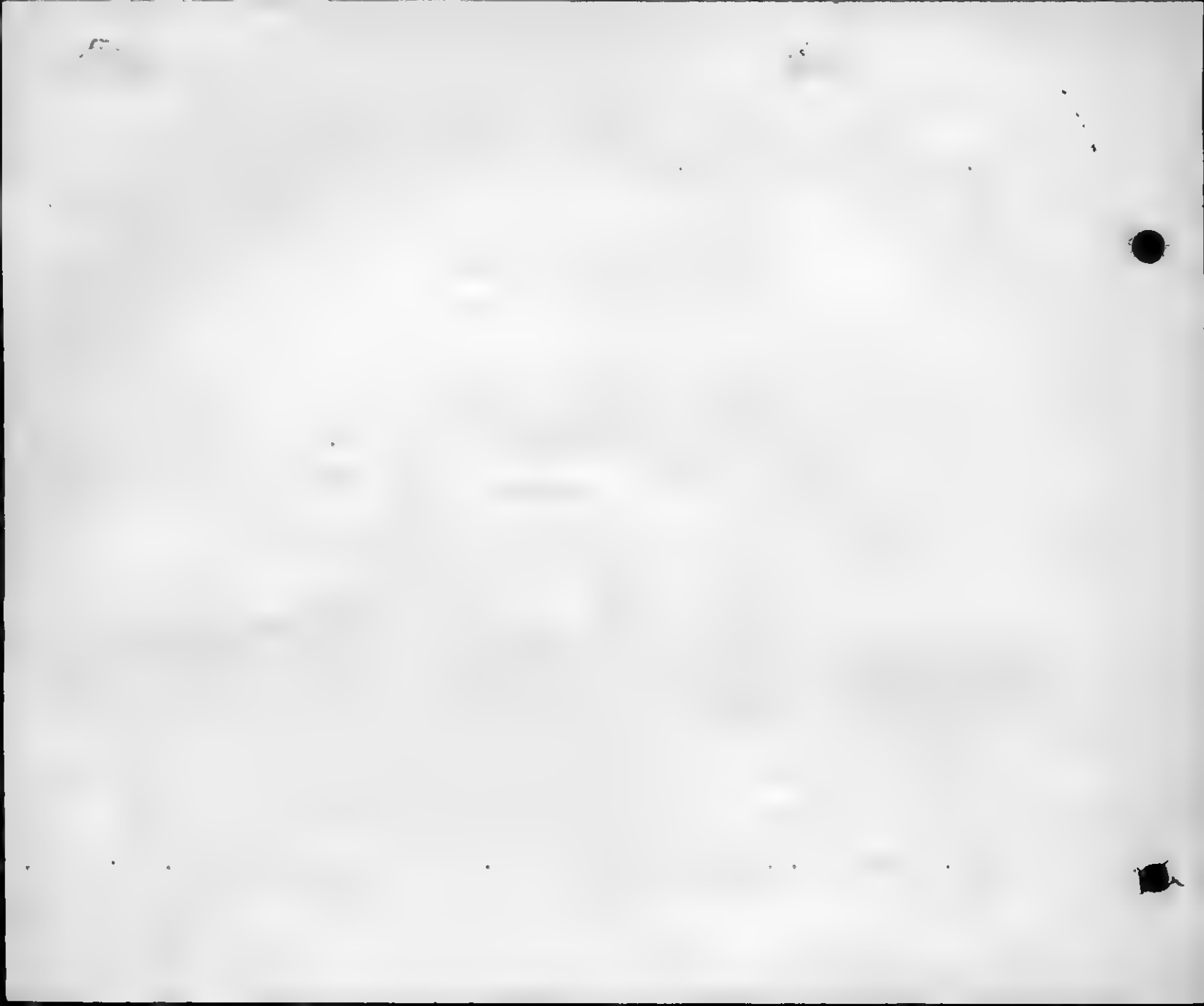
11054

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE Quartermaster b. COUNTY Severn, Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel Co	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS Quartermaster Rd, 02x	
3. NAME OF DECEASED (Type or print) First Albert Middle Frederick Last Leichgrabe		4. DATE OF DEATH Month 10 Day 30 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-1896
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Leichgrabe		14. MOTHER'S MAIDEN NAME Louise Schoning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-03-0022	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculosis of the Lungs		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/31 1961, to 10/30 1961, that (I) (we) last saw the deceased alive on 10/30 1961, and that death occurred at 10/30 M, from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 10/30/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3rd Nov. 61	
23c. NAME OF CEMETERY OR CREMATORY Glenn Burnie		23d. LOCATION (City, town, or county) (State) Glenn Burnie Rd	
24. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		25a. REC'D BY REGISTRAR Glenn Burnie, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE NOV 6 '61	

bp



<div>Item 18 Film 309 5-22-61</div> <div>11065</div> <div>CERTIFICATE OF DEATH</div> <div>11055</div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>5 mo. 21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>						d. STREET ADDRESS <u>2025 Rozano Ke St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Libbey</u> Last <u>Delehanty</u>						4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/21/07</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edward W Libbey</u>						14. MOTHER'S MAIDEN NAME <u>Edith Hoffman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>577-10-4983</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far Advanced Pulmonary Tuberculosis</u> (10 mo) INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u> (b) <u>Cor Pulmonale</u> (c) <u>Emphysema</u> Part II <u>Bronchitis Asthma</u> <u>20 yrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>1 FAY / 1 A / 1 H / 1 K / 1 L / 1 P / 1 M / 1 D / 1 V / 1 T / 1 B / 1 N / 1 G / 1 S / 1 U / 1 I</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> 19 <u>61</u> to <u>10/2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/2</u> 19 <u>61</u> , and that death occurred at <u>10:35 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W Newcomer</u>						M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED <u>10/2/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>						22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem</u>		23d. LOCAT ON (City, town, or county) (State) <u>COLUMBIA MANOR Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Tim See 4 Sons</u>				ADDRESS <u>300 4th St NE</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thoms</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (11)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11066 CERTIFICATE OF DEATH 11056

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights	
4. DATE OF DEATH Month October Day 17 Year 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gene Middle Deac Last Deac		4. DATE OF DEATH Month October Day 17 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Lichtenstein		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. George Desi-		Address 300 Eva Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Discompensation 422 DUE TO (b) Chronic Atherosclerotic Cardio Vascular Disease DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 7d. 1031'	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) marked microcytic anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to Oct 17, 1961 , that (I) (we) last saw the deceased alive on 10-17 1961, and that death occurred at 4PM , from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D.		22d. ADDRESS 6209 Frederick Ave. Balt. 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Oct 18 1961	
23c. NAME OF CEMETERY OR CREMATORY Riverside		23d. LOCATION (City, town, or county) (State) New York	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc.		25a. REC'D BY REGISTRAR OCT 23 '61	
ADDRESS 6010 Reist Road		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
11067
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11057
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3: 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bent Nursing Home 800 Main Street		d. STREET ADDRESS 3311 Chestnut Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Leonard J. Dorsey		4. DATE OF DEATH Month Day Year October 11 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1890
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Insulation		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. Dorsey		14. MOTHER'S MAIDEN NAME Josephine D. Jardine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-4263	
17. INFORMANT L. P. Almony		Address 924 Lindellen Ave., Reisterstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 30, 1961 to October 11, 1961 , that (I) (we) last saw the deceased alive on October 11, 1961 , and that death occurred on Oct 11, 1961 at 2:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Clarence E. McWilliams M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Clarence E. McWilliams		22d. ADDRESS Reisterstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF Oct. 11, 1961	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace P. Burgee		25a. REC'D BY REGISTRAR DATE OCT 13 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

24-25

CERTIFICATE OF DEATH

Reg. Dist. No.

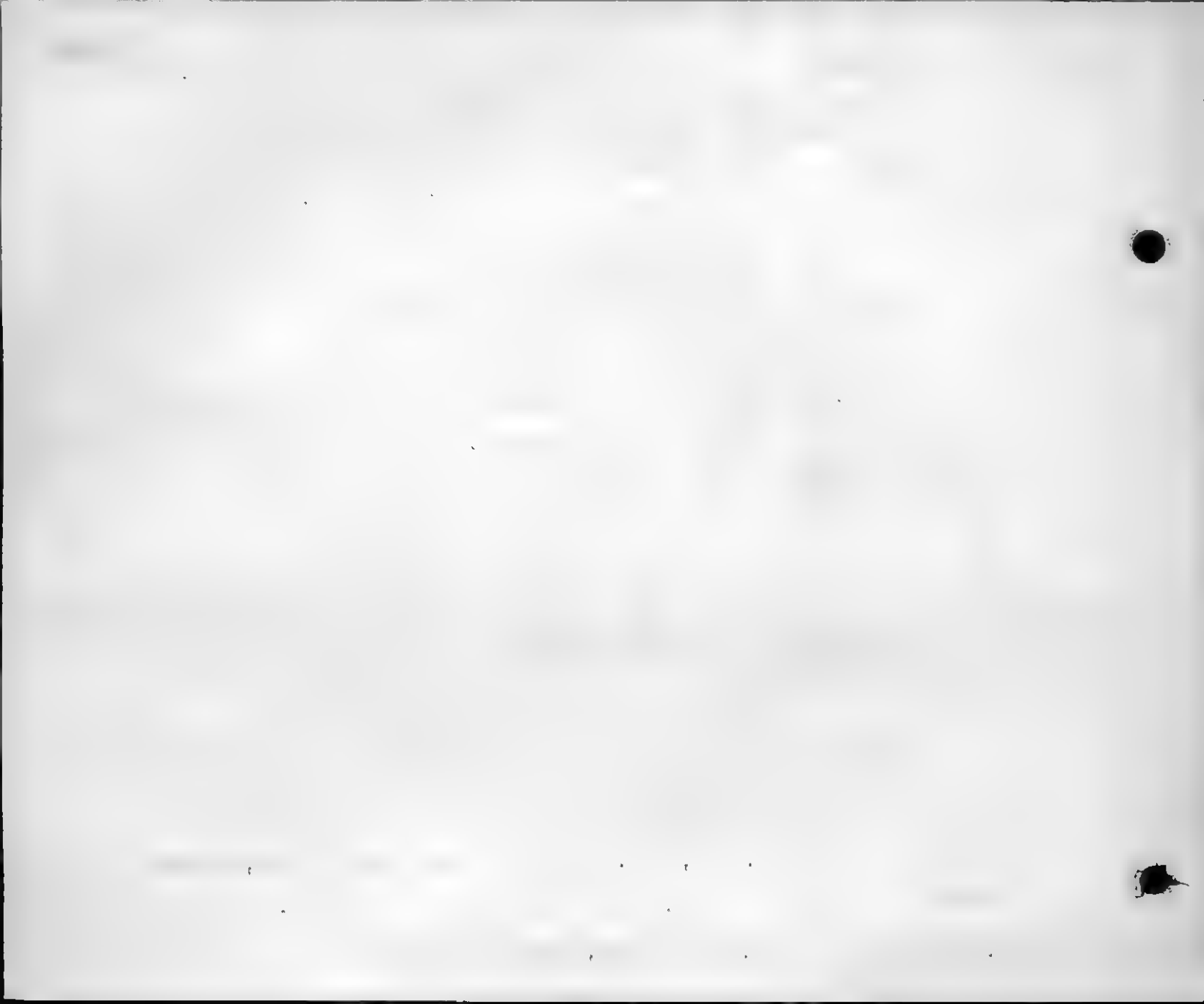
11058

11068

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Agel Homes + Agel Home Home</u>		d. STREET ADDRESS <u>3257 Chestnut Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>May</u> Last <u>Dwyer</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1866</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Coomes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daisy E. Hammett</u>		Address <u>615 Chestnut Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Nephrosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Renal Disease</u> DUE TO (c) <u>3 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>October 15, 1961</u> , that I last saw the deceased alive on <u>October 13, 1961</u> , and that death occurred at <u>3:30 a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland E. Day</u>		ADDRESS (Street, city or town, state) <u>4-E-33rd St Balto. 18 Md October 16, 1961</u>	
PHYSICIAN'S NAME (Type) <u>Newland E. Day, M.D.</u>		DATE SIGNED <u>4 East 33rd Street, Baltimore 18</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-17-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hampden, Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2</u>		ADDRESS <u>4 East 33rd Street, Baltimore 18</u>	
24a. REC'D BY REGISTRAR <u>OCT 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Rouse</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

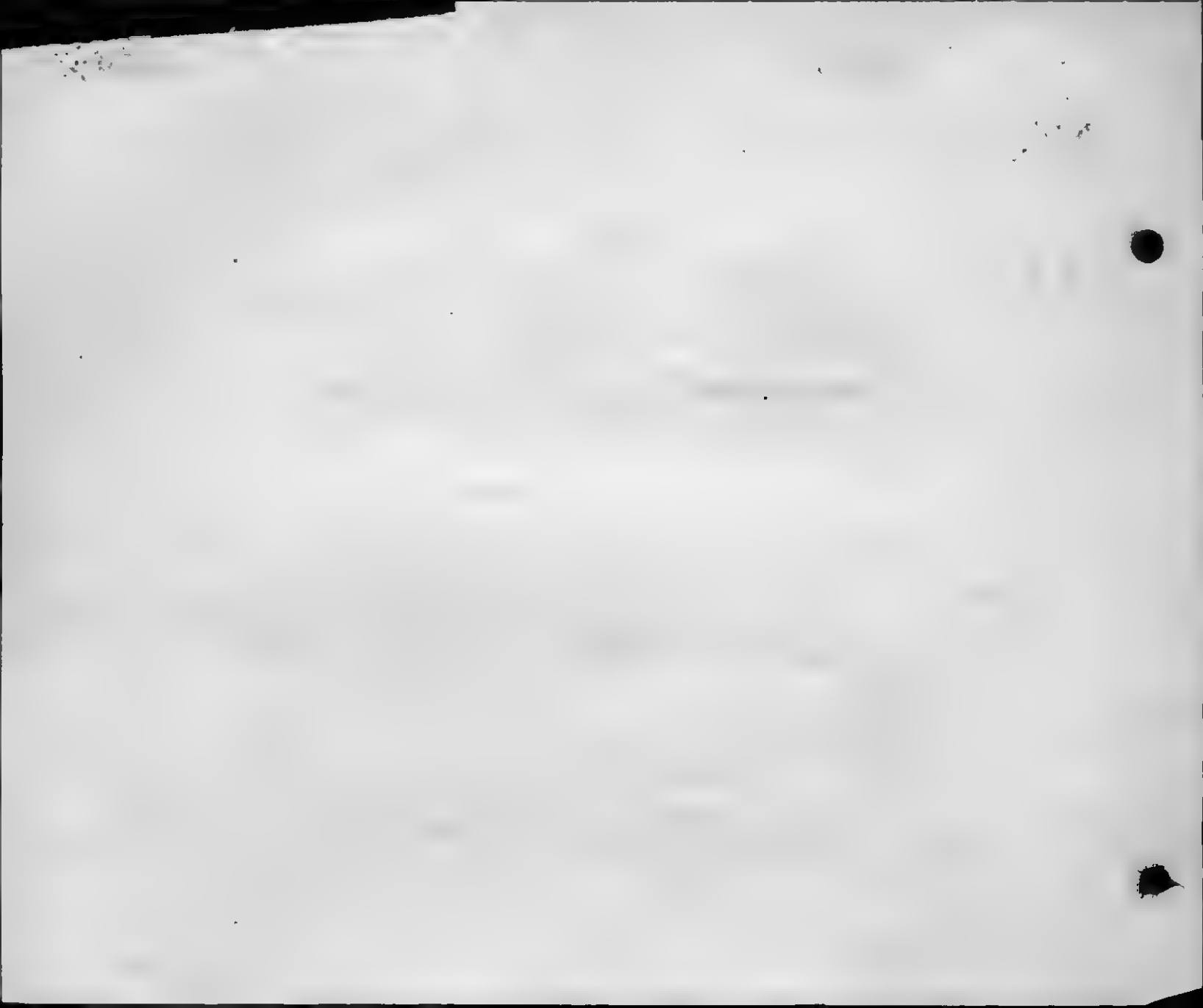
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11069

CERTIFICATE OF DEATH

11059

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> d. STREET ADDRESS <u>76 River Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary E. Eagle</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/9/1881</u>	9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rufus N. Wathall</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Zone 29</u>	
17. INFORMANT <u>Rosalie Baacke, step-daughter, 613 Brookwood Rd</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIO SCLEROTIC CV DISEASE. PARKINSON'S DISEASE.</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH 1 WEEK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <u>ARTERIO SCLEROTIC CV DISEASE. PARKINSON'S DISEASE.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-27-1960</u> <u>6:45 A.M.</u> to <u>10-10-1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>10-6-1961</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John F. Schaefer</u>		22b. DATE SIGNED <u>10/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER</u>		22d. ADDRESS <u>401 RANDOM ROAD-29</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u>		25a. REC'D BY REGISTRAR <u>Calvin L. Thomas</u>	
25b. REGISTRAR'S SIGNATURE <u>3331 Greens Lane</u>		DATE <u>OCT 13 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11070

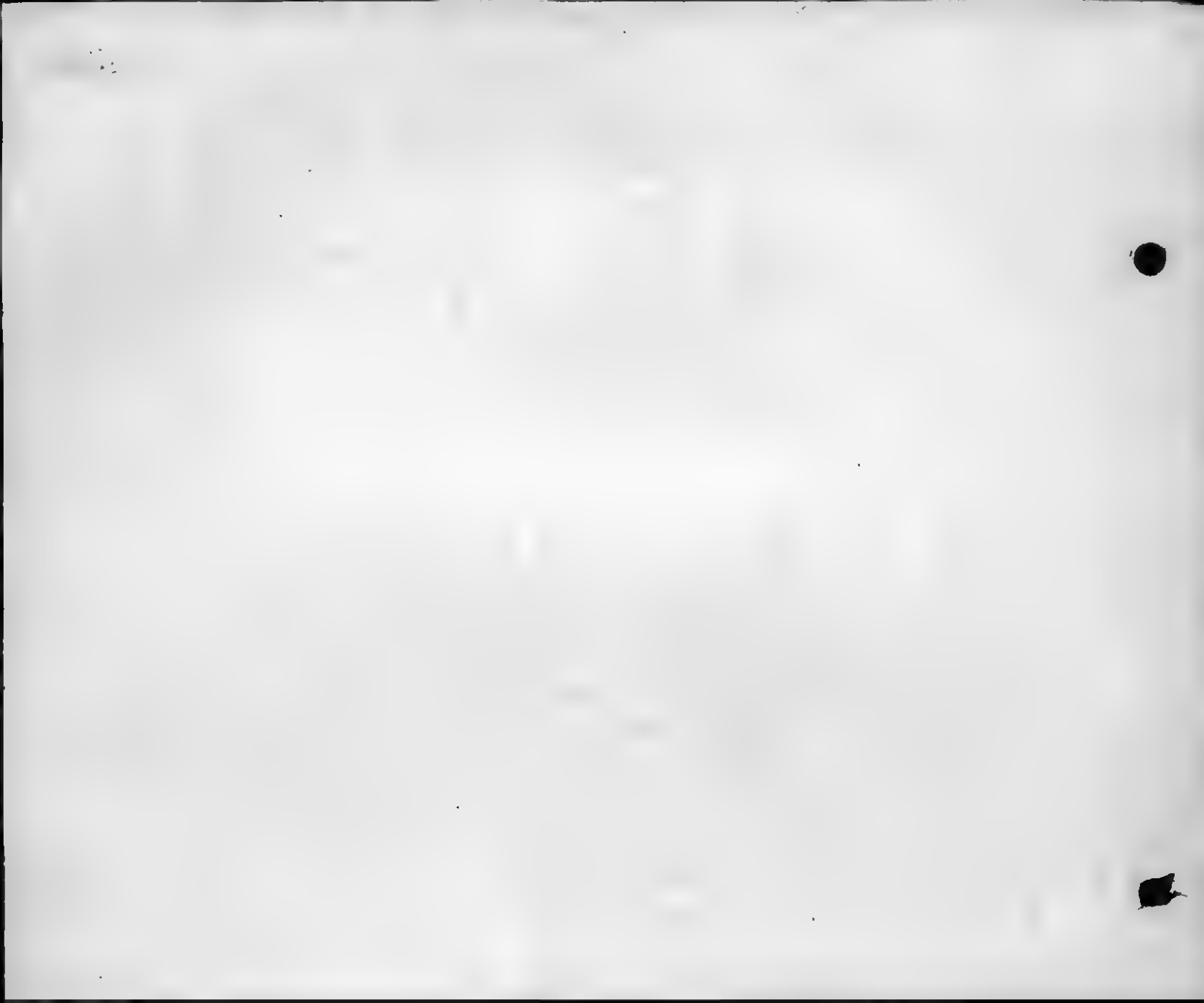
CERTIFICATE OF DEATH

Reg. Dist. No. 11060

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Halethorpe, Md.</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>15624 Carville Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>C.</u> Last <u>Earehart</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1906</u>
9. AGE (In years last birthday) yrs. <u>54</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Woosley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-4836</u>	
17. INFORMANT <u>Paul Earehart</u>		Address <u>5624 Carville Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Mitral Stenosis</u> DUE TO (b) <u>Rheumatic heart disease.</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>61</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles L. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>910 W. Lombard St. Balt 23 Md.</u>	
PHYSICIAN'S NAME (Type) <u>Oct 8/1961</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 10-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. GENERAL DIRECTOR'S SIGNATURE <u>Frank J. Perry</u>		ADDRESS <u>5646 Carville Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





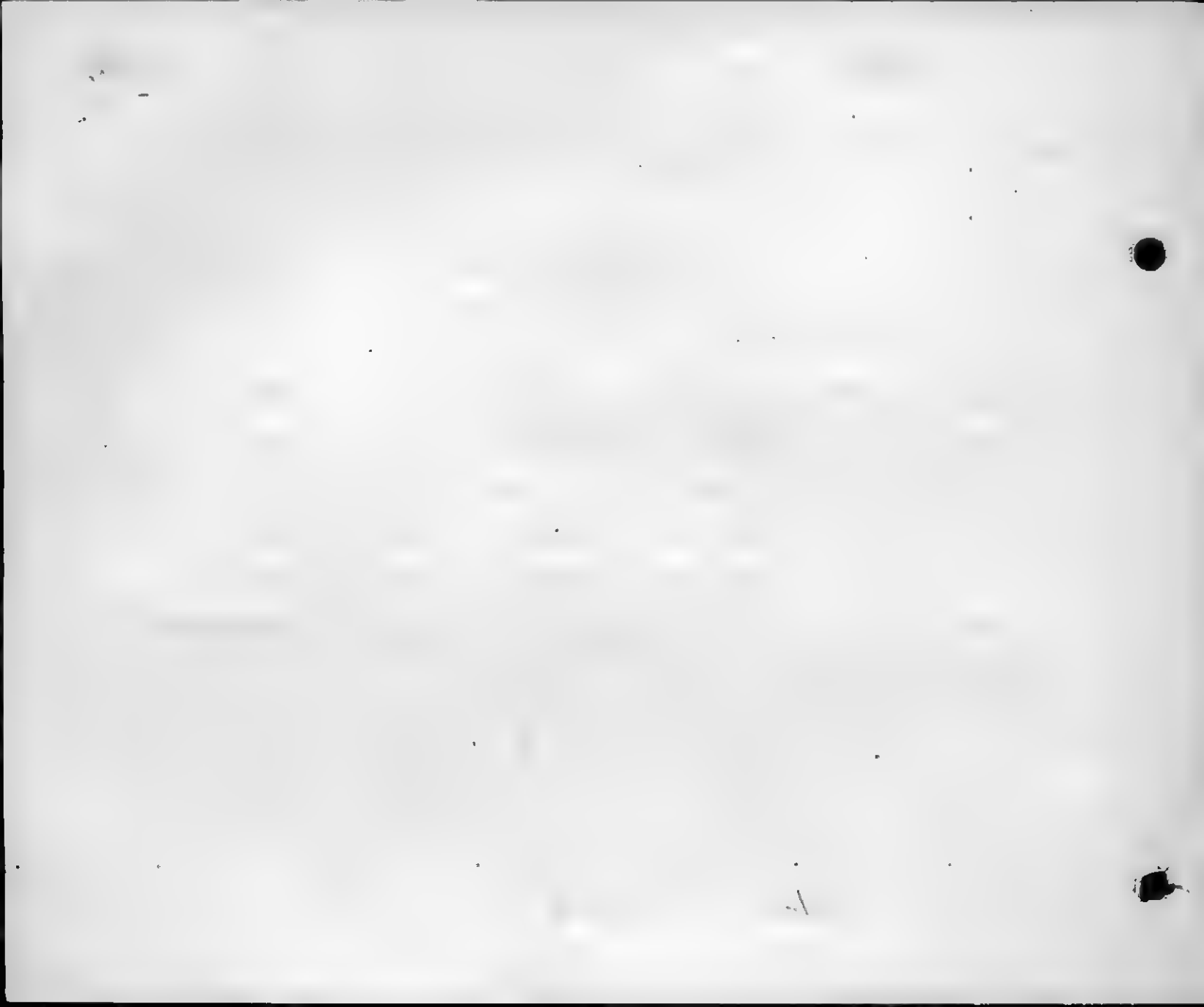
CERTIFICATE OF DEATH

11071

Item 230, Film GC99 11/0/01 invs

11061

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 months Rural P GAMBRISS (GLENBURNIE)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>P.O. # 33</u>	
3. NAME OF DECEASED (Type or print) First <u>LEE</u> Middle <u>GRANT</u> Last <u>EDWARDS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-07</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOILER MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOILER MAKING</u>	
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT M. EDWARDS</u>		14. MOTHER'S MAIDEN NAME <u>HENERIETTA MATTHEWS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>575-22-3042</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <u>CARDIAC FAILURE</u> DUE TO (b) <u>INFARCTION OF MYO CARDIUM</u> DUE TO (c) <u>ARTERIO SCLEROTIC CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MODERATELY ADVANCED PULMONARY TUBERCULOSIS-PLEURISY WITH EFFUSION</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>002X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u> </u> (this hospital) attended the deceased from <u>10-21-1961</u> to <u>10-29-1961</u> that <u> </u> (we) last saw the deceased alive on <u>10-28-1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>W. Newcomer</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>W. Newcomer, I.D., Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 1 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen Ch. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Mt. Wilson, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		25. REGISTRAR'S SIGNATURE <u>W. Newcomer</u>	
DATE <u>NOV 1 1961</u>		DATE <u> </u>	

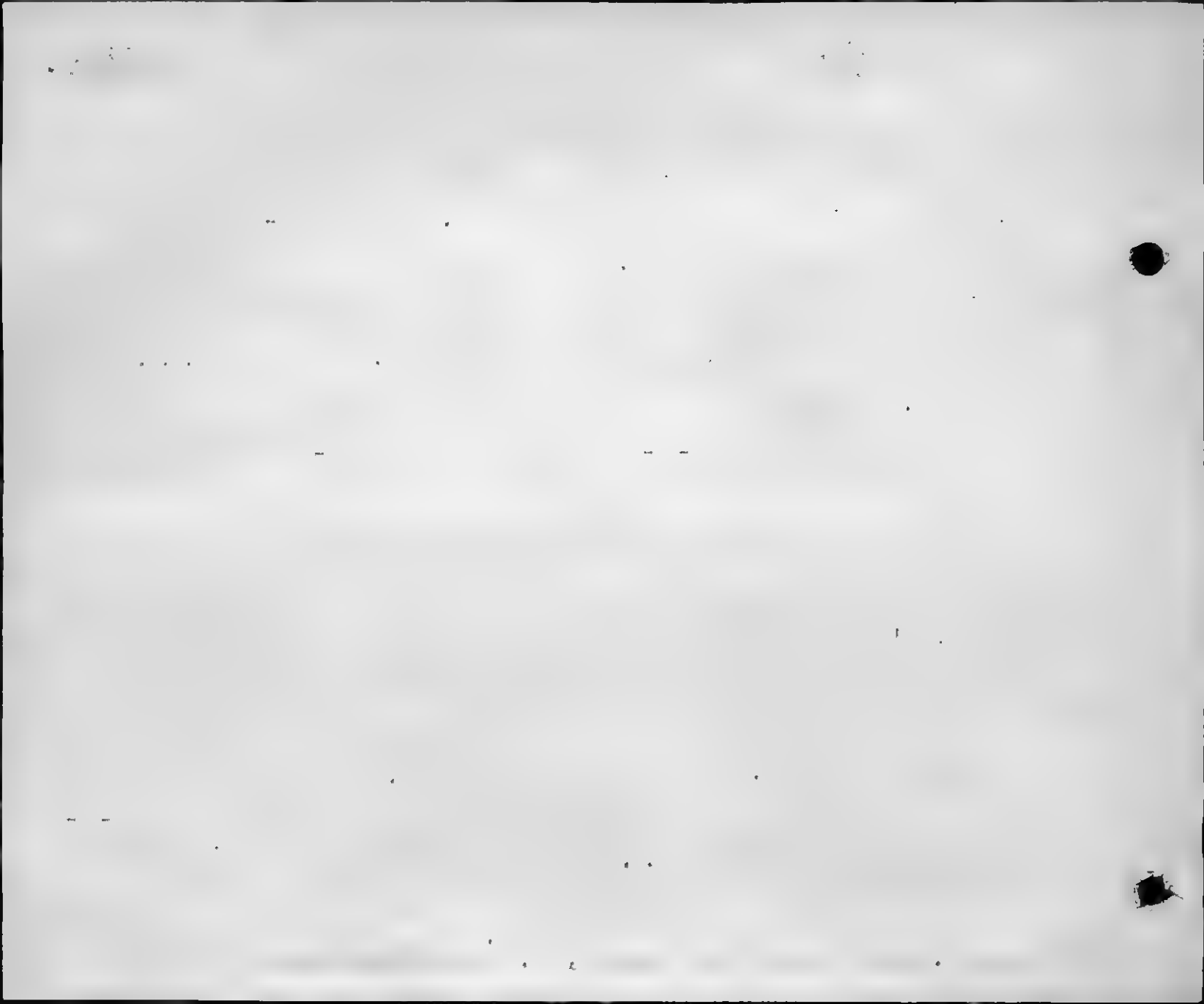


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11072					11062						
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>					c. LENGTH OF STAY IN lb <u>31 days</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>					e. STREET ADDRESS <u>426 E. Eager Street - 2</u>						
3. NAME OF DECEASED (Type or print) <u>ROBERT L. EDWARDS</u>					4. DATE OF DEATH <u>October 14 1961</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1919</u>		9. AGE (In years last birthday) <u>42</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pinola, Miss.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John D. Edwards</u>					14. MOTHER'S MAIDEN NAME <u>Rose Thompson</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW-11</u>					16. SOCIAL SECURITY NO. <u>213-28-2676</u>					17. INFORMANT <u>Clinical Records, VA Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>LAENNEC'S CIRRHOSIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>UNKNOWN</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LAENNEC'S CIRRHOSIS</u>					19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u>		20g. (County) <u>Baltimore</u>		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 13, 1961</u> to <u>Oct. 14, 1961</u> that (I)(we) last saw the deceased alive on <u>Oct. 14, 1961</u> and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Ralph N. Lee</u>					22b. DATE SIGNED <u>10-15-61</u>		22c. PHYSICIAN'S NAME (Type) <u>RALPH N. LEE</u>			22d. ADDRESS <u>VAH, Baltimore 18, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>10-18-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>					24a. ADDRESS <u>Balto 17, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		



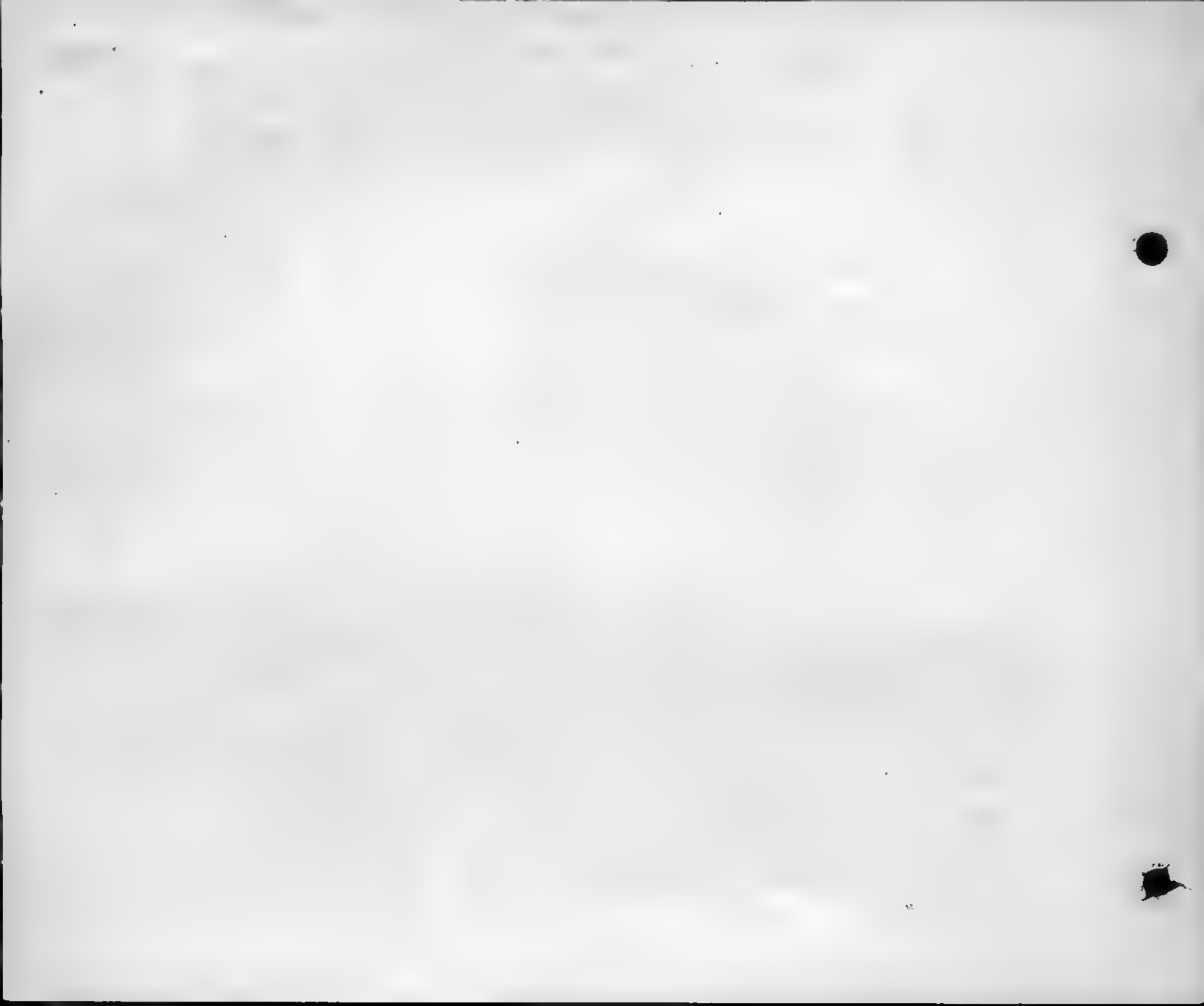
Reg. Dist. No. 11063

VS A15 (4)
15M 10/57

M

(I)

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Maria - Notch Cliff				d. STREET ADDRESS Glenarm, Maryland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister M. Joan of Arc (Ehmann)				4. DATE OF DEATH Month 10 Day 21 Year 1961			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1893	
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 7 Days 18 Hours 15 Min 00		11. IF UNDER 24 HRS Hours 15 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME John Ehmann				14. MOTHER'S MAIDEN NAME Anna M. Schinerbach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 1-10-61			
17. INFORMANT Sr. M. Henrica				Address Villa Maria, Glenarm, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Artirio-schlerotic vascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic (c) hypertension							
INTERVAL BETWEEN ONSET AND DEATH 55 hours 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19-10-61							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 10:40				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Towson				(County) Baltimore		(State) Md.	
21. I certify that I attended the deceased from November 19, 1961 to October 21, 1961 , that I last saw the deceased alive on Oct. 21, 1961 , and that death occurred at 10:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md.			
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-24-61		22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCHCLIFF NR TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler				24a. REC'D BY REGISTRAR DATE 10/26/61		24b. REGISTRAR'S SIGNATURE W. S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

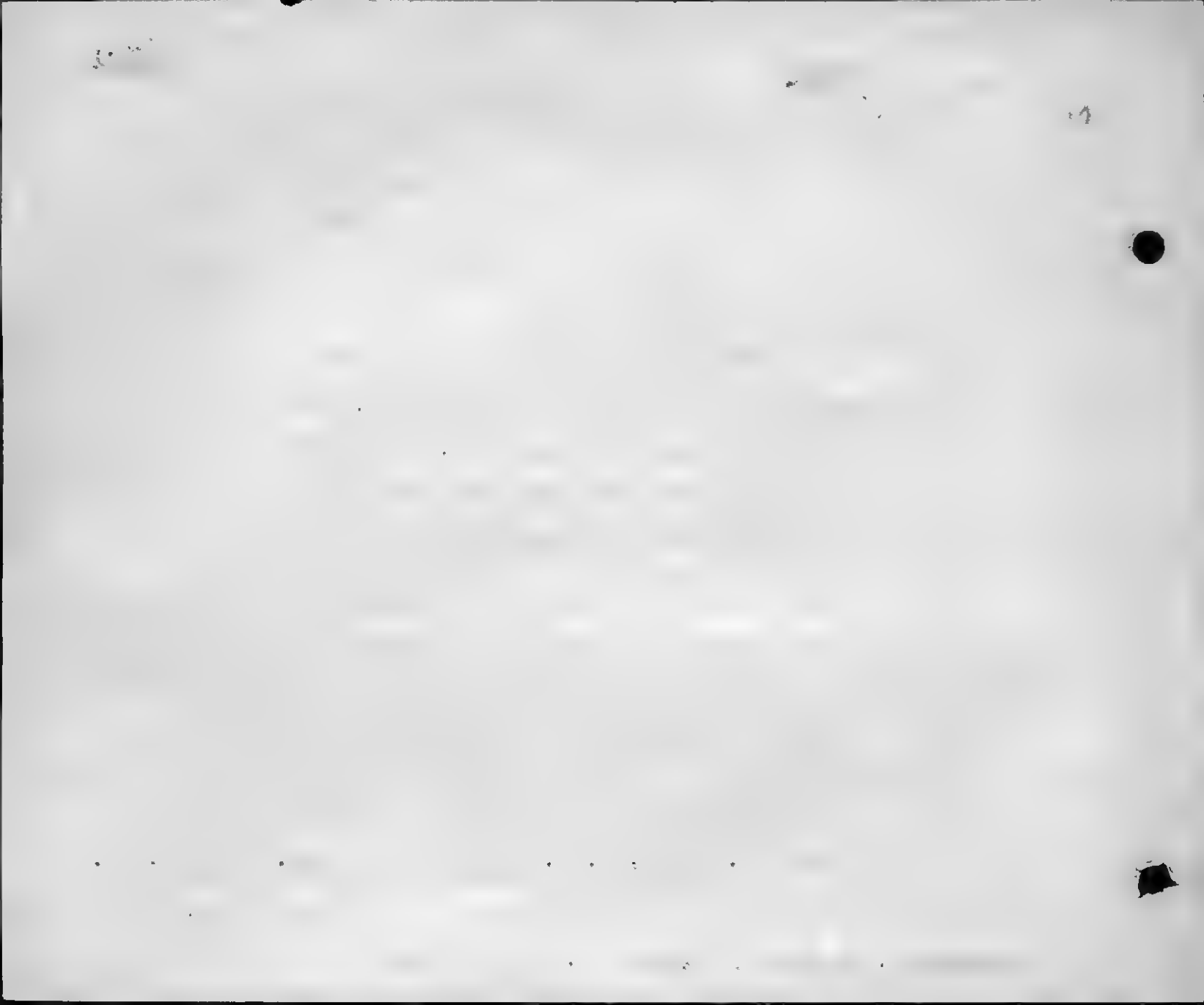
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11074

11064

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> c. LENGTH OF STAY IN Tb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 44 A Chapel Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> d. STREET ADDRESS <u>Box 44 A Chapel Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Jane</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-1902</u> 9. AGE (In years, last birthday) <u>58</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife and saleslady</u> 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		4. DATE OF DEATH <u>October 1</u> 19 <u>61</u> 13. FATHER'S NAME <u>Grady Merrell</u> 14. MOTHER'S MAIDEN NAME <u>Martha F. Edwards</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>193X</u> 16. SOCIAL SECURITY NO. <u>215346618</u> 17. INFORMANT <u>Joseph B. Miller</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Abdominal Carcinoma</u> DUE TO (c) <u>193X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval between onset and death 8 to 10 months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>61</u> to <u>Oct 1</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 13</u> 19 <u>61</u> , and that death occurred at <u>8:30</u> a.m. from the causes and on the date stated above.		22a. SIGNATURE <u>Theodore E. Evans</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Theodore E. Evans, M.D.</u> 22b. DATE SIGNED <u>9660 Belair Rd. Balto 6, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>10-3-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> 25a. REC'D BY REGISTRAR <u>Oct 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



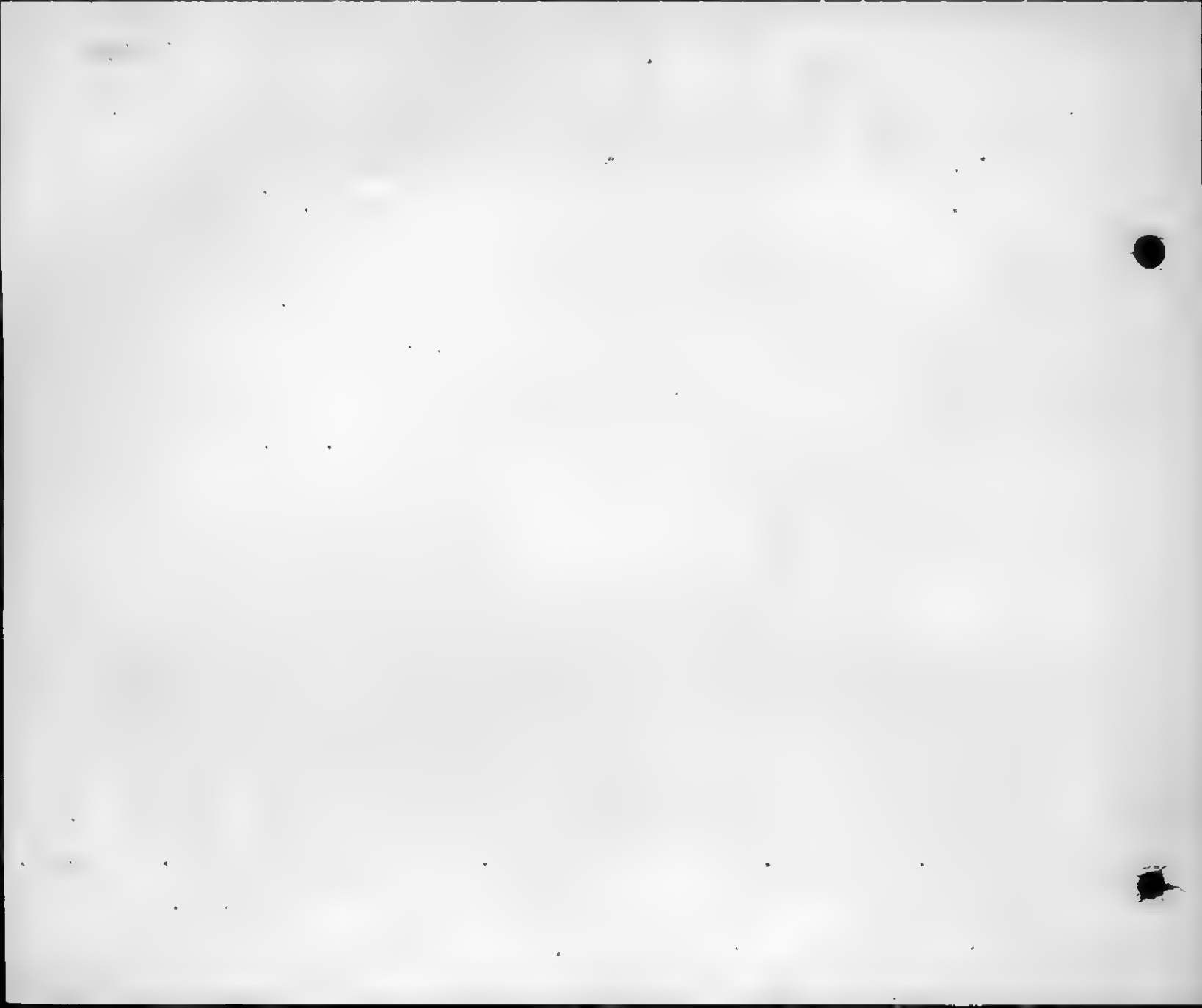
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11075

11065

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. STREET ADDRESS <u>6430 Auburn Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Olive</u> Last <u>Ericson</u>				4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/23/1897</u>		9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Translator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Ericson</u>				14. MOTHER'S MAIDEN NAME <u>Melisa O. Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Oedema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u> <u>11 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Far Advanced Pulmonary Tuberculosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> 19 <u>61</u> , to <u>10/9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> 19 <u>61</u> , and that death occurred on <u>8 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. Newcomer</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 9, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>				22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. RECEIVED BY REGISTRAR <u>Oct 11 61</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

11066

11076

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>5 WKS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATON RIDGE NURS. HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> d. STREET ADDRESS <u>4431 OLD FREDERICK RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLAUDE W. FARRAR</u> 5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>MAY 24, 1902</u> 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____				4. DATE OF DEATH <u>OCT. 9, 1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER, LOUDON PK. CEMTY.</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM FARRAR</u> 14. MOTHER'S MAIDEN NAME <u>MINNIE MALLORY</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>MRS RUBY PEETZ</u> Address <u>RD. 4431 OLD FREDERICK</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogen Carcinoma Left Lung and Metastases</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> to <u>10/11</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> , 19 <u>61</u> , and that death occurred at <u>11</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles A. Cahn</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/11/61</u>				22c. PHYSICIAN'S NAME (Type) <u>Charles A. Cahn</u> 22d. ADDRESS <u>2145 W. Baltimore St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEMTY.</u>		23d. LOCATION (City, town or county) <u>BALTO. MD.</u> (State) _____	
24. BURIAL DIRECTOR'S SIGNATURE <u>WITZKE F. DR.</u> ADDRESS <u>4101 EDMONDSON AVE</u>				25a. REC'D BY REGISTRAR <u>16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be filled in by the attending physician and completed by the funeral director. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

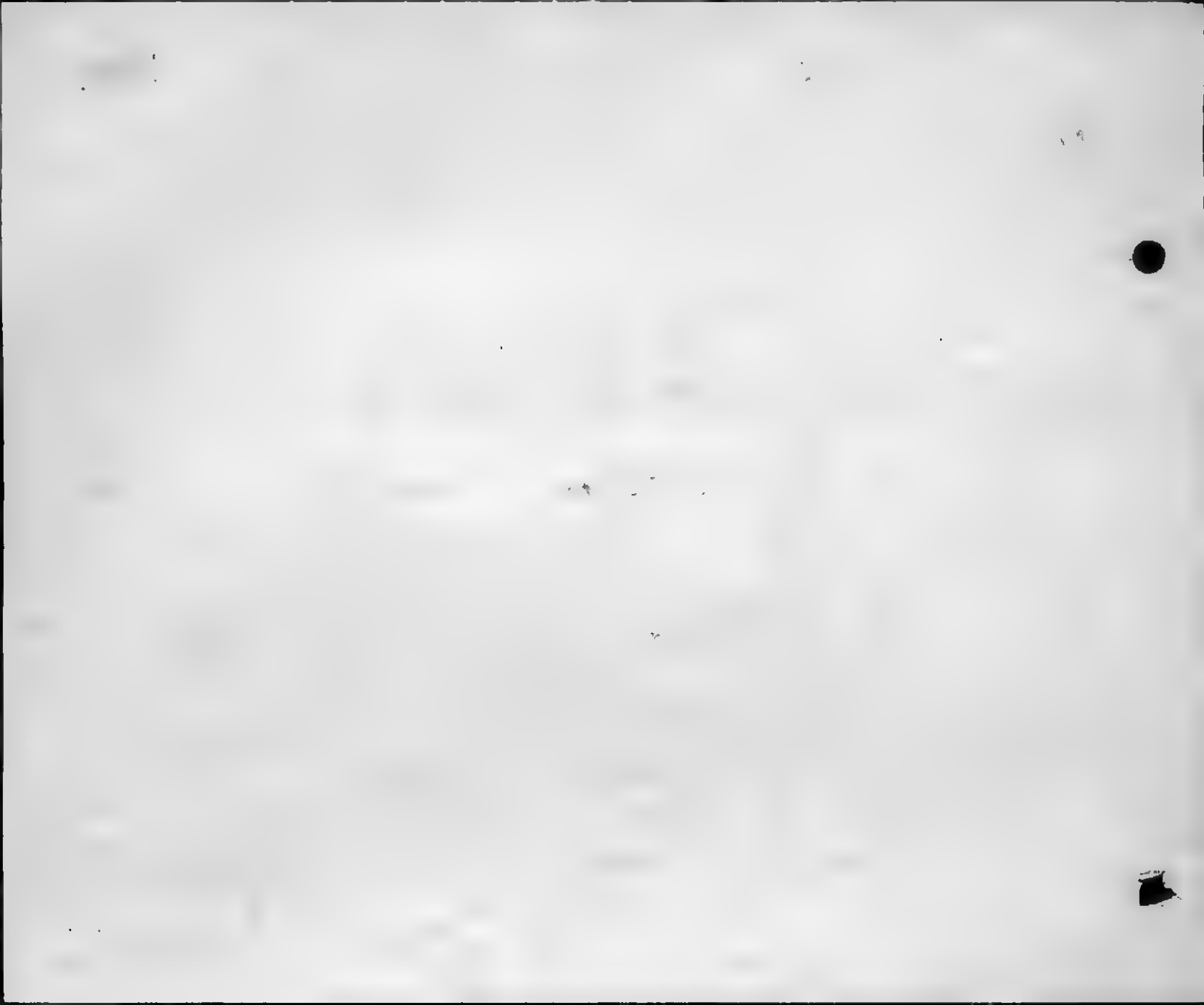
11077

11067

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>3 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST JOSEPH'S NURSING HOME</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4222 VERMONT AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>AGNES</u> Last <u>FEDERLINE</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>27</u> Year <u>1961</u>		
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 5, 1881</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. PLACE (County & State, or foreign country) <u>Ind. U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN MULCAHY</u>			14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Wm. P. Federline - 4222 Vermont Ave.</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.5</u> DUE TO <u>Intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>		
21. I certify that (I) (this hospital) attended the deceased from <u>April 24, 1961</u> to <u>Oct 27, 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 24, 1961</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>James E. Rowe</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JAMES E. ROWE</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1011 Frederick Rd</u> 22b. DATE SIGNED <u>10/29/61</u> <u>#28</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>	
23d. LOCATION (City, town or county) <u>Bald.</u> (State) <u>Ind.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u> ADDRESS <u>-</u> 25a. REC'D BY REGISTRAR <u>NOV 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11078

CERTIFICATE OF DEATH

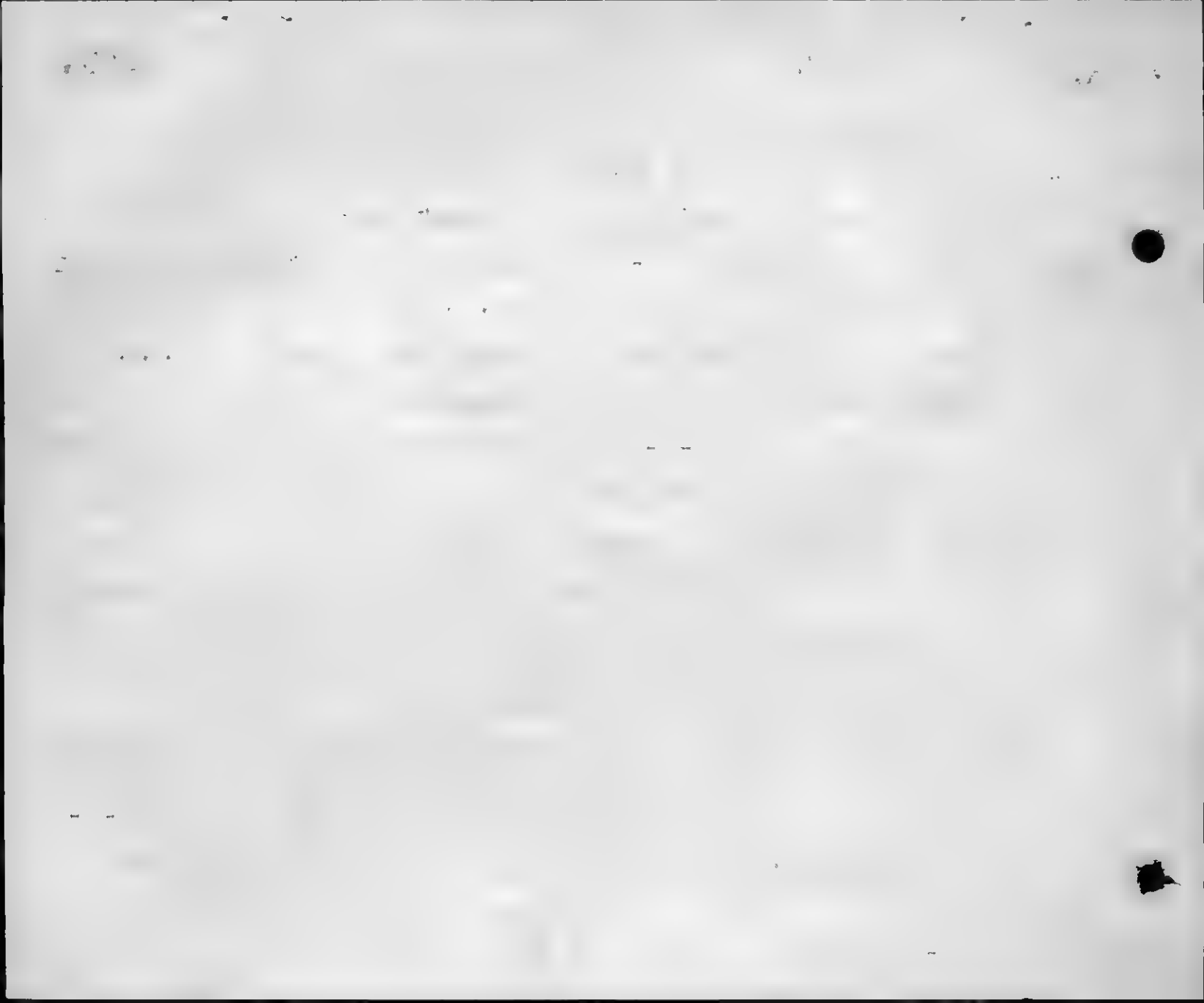
11068

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>45 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>318 Park Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAWRENCE</u> First <u>FITZGERALD</u> Middle <u>---</u> Last 4. DATE OF DEATH <u>October 13</u> 19 <u>61</u> 9. AGE (In years last birthday) <u>66</u> yrs. 10. IF UNDER 1 YEAR: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 3, 1895</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Albemarle Co Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Fitzgerald</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-1</u> 16. SOCIAL SECURITY NO. <u>219-01-0014</u> 17. INFORMANT <u>Clin Rec VAH Baltimore Md Ft Howard Division</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (b) <u>CA OF PANCREAS</u> (c) <u>BILIARY CIRRHOSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhagic Cystitis</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State) 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 29, 1961, to Oct. 13, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 13, 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Arthur T. Faulk</u> M.D. 22b. DATE SIGNED <u>10-14-61</u> 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR T. FAULK, M.D.</u> 22d. ADDRESS <u>VAH Baltimore 18 Md Ft Howard Division</u> 23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>10-17-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u> 25a. REC'D BY REGISTRAR <u>OCT 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

MEDICAL CERTIFICATION

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

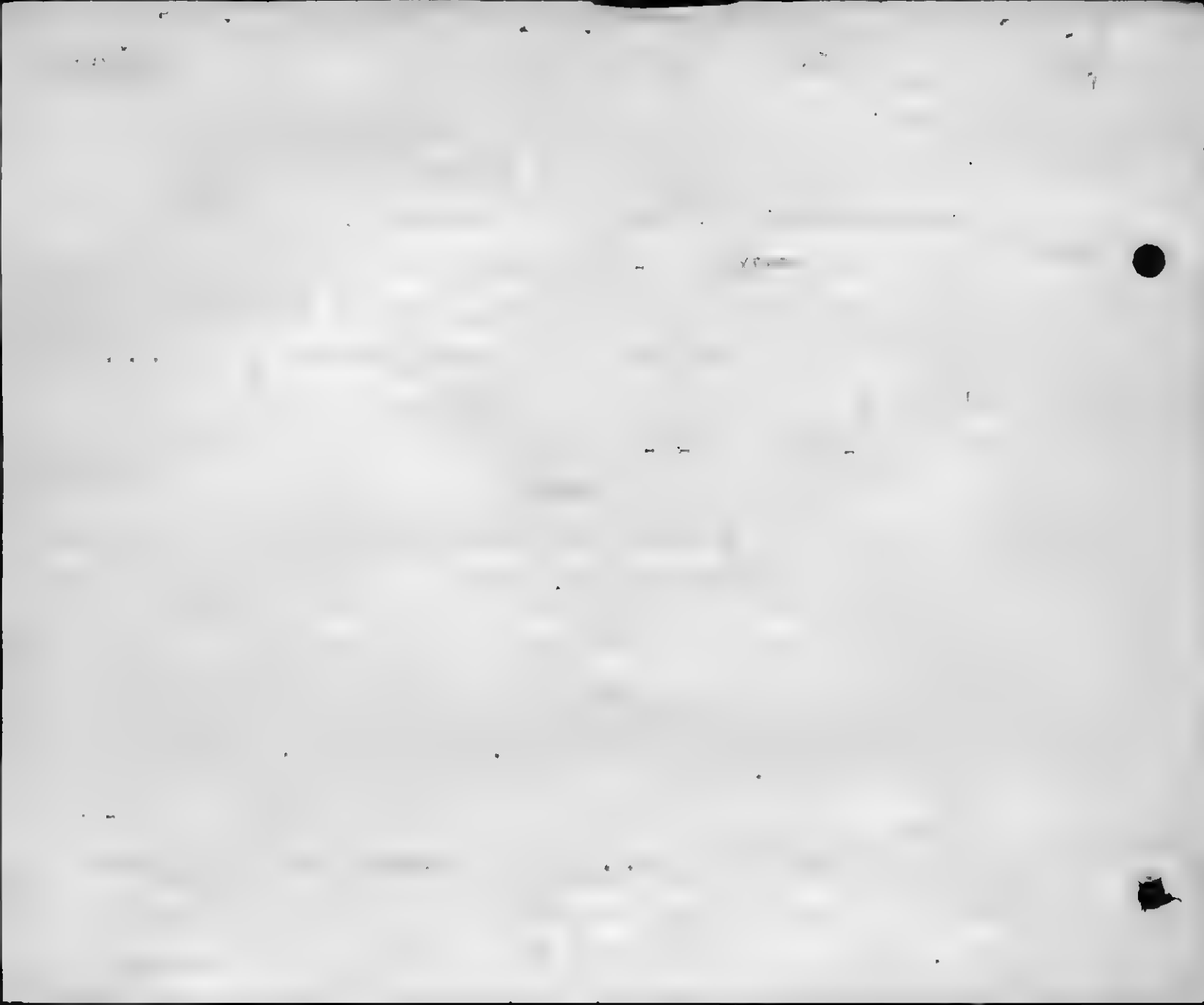
VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
11079
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11069

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1010 Lamont Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FELIX First Middle Last 4. DATE OF DEATH October 8 1961 Month Day Year		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1898 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 13. FATHER'S NAME Bill Fleming		10b. KIND OF BUSINESS OR INDUSTRY Brick Yard 14. MOTHER'S MAIDEN NAME Unknown		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. WW-1 218-09-5277		17. INFORMANT Clin Rec VAH Balto Md Ft Howard Division Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERAL			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 5, 1961 , to Oct. 8, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 8, 1961 , and that death occurred at 5:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Paul Bormel 22c. PHYSICIAN'S NAME (Type) Paul Bormel M.D.		22b. DATE SIGNED 10-8-61 22d. ADDRESS VAH Baltimore Md - Ft Howard Division		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-11-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National 23d. LOCATION (City, town or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR DATE OCT 11 '61		25b. REGISTRAR'S SIGNATURE William L. House			

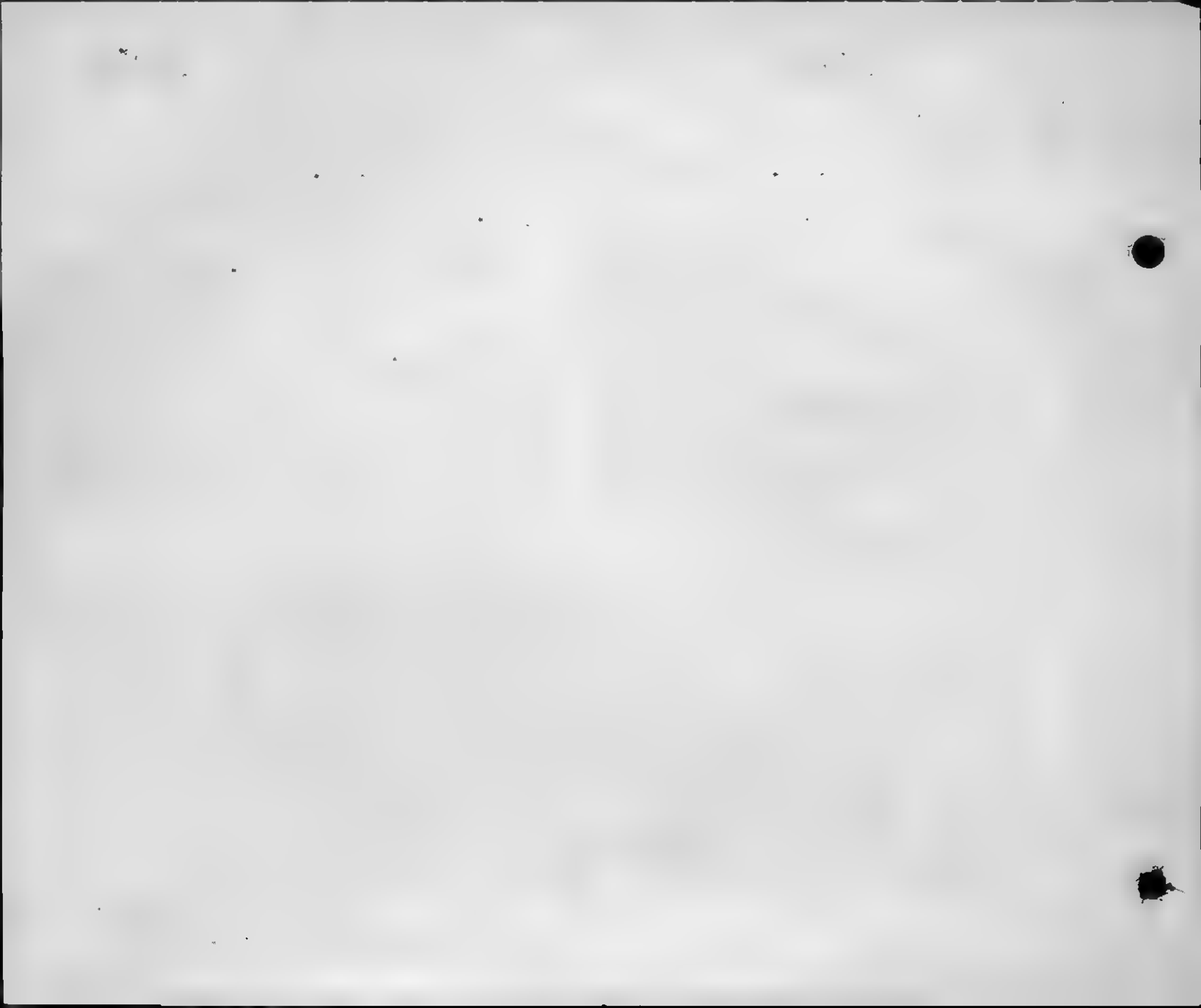


FOR STATE HEALTH DEPT. M X I

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethlehem Steel Hospital</u>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>17C</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u> d. STREET ADDRESS <u>Rt. 14 Box 295</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) <u>Milton Burnett Fortman</u>				4. DATE OF DEATH <u>October 26 1961</u>				5. SEX <u>M</u>				6. COLOR OR RACE <u>white</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>7/4/08</u>				9. AGE (In years last birthday) <u>53</u>				10. IF UNDER 1 YEAR Months Days				11. IF UNDER 24 HRS. Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintainance</u>								10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>								11. BIRTHPLACE (State or foreign country) <u>Balto Co. Md</u>								12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>																							
13. FATHER'S NAME <u>John Fortman</u>								14. MOTHER'S MAIDEN NAME <u>Carrie Unknown</u>								15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>								16. SOCIAL SECURITY NO. <u>214-16-3197</u>								17. INFORMANT <u>Mrs Thelma G Fortman</u> Address <u>Box 295 Balto 20 Md.</u>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>72011</u> DUE TO <u>Ceremony</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Cocclusion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval BETWEEN ONSET AND DEATH 1 hr</u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																																			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																															
SIGNATURE <u>Jack E Collins</u> M.D.																CHIEF MEDICAL EXAMINER <input type="checkbox"/>																															
EXAMINER'S NAME (Type) <u>Jack E Collins</u>																ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																															
																DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																															
																Address (Street, city, town, or county)																															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								22b. DATE THEREOF <u>10-30-1961</u>								22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Meth Cemetery</u>								22d. LOCATION (City, town, or country) (State) <u>Chase Maryland</u>																							
23. FUNERAL DIRECTOR <u>Richard H. Laver</u> ADDRESS <u>14-52-11</u>																24a. REC'D BY REGISTRAR <u>16-2761</u> DATE <u>OCT 30 '61</u>																24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>															



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11081

11071

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oella</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>739 Oella Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oella</u> d. STREET ADDRESS <u>739 Oella Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Madalen France</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>1961</u>		5. SEX <u>Female</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/10/01</u>			
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Pfeiffer</u>			
14. MOTHER'S MAIDEN NAME <u>Brooks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>745A</u>		17. INFORMANT <u>Mrs. Katherine Lemmerman</u> Address <u>1303 Frederick St Catonsville 28 md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure Acute</u> (b) <u>Hypertensive Cardio Vascular</u> (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Oct 1960</u>			
20f. (City or town) <u>10/12/61</u>		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/2/61</u> to <u>10/12/61</u> that (I) last saw the deceased alive on <u>10/2/61</u> and that death occurred <u>10/12/61</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.E. McGrath</u>		22b. DATE SIGNED <u>10/12/61</u>		22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath M.D.</u>			
22d. ADDRESS <u>1303 Frederick St Catonsville 28 md</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>			
23d. LOCATION (City, town, or county) <u>Howard Co. Md</u>		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <u>Arthur J. Hanna</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don</u>		24a. ADDRESS		24b. DATE <u>OCT 16 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

1911-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

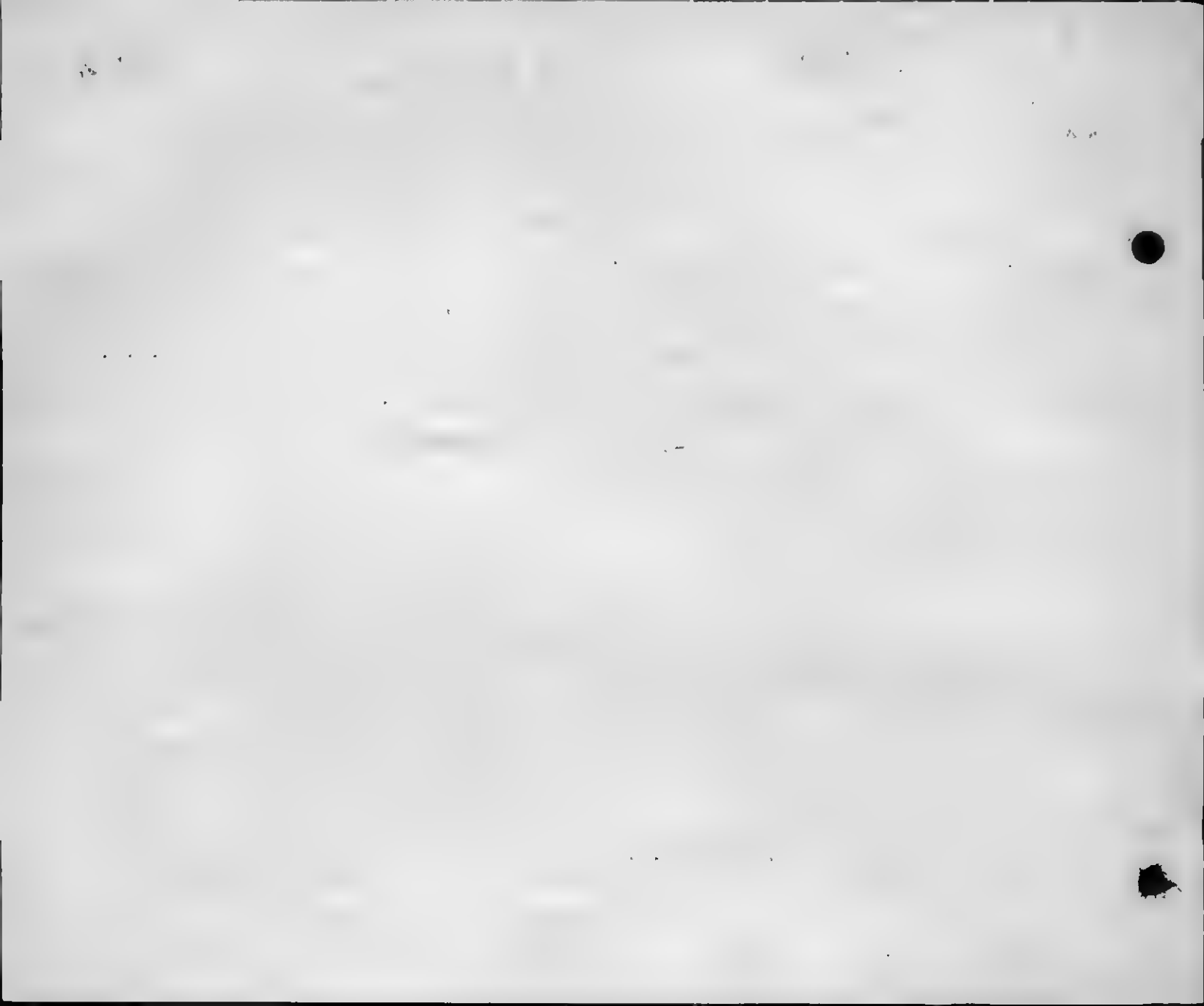
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11082

CERTIFICATE OF DEATH

11072

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u> c. LENGTH OF STAY IN <u>1b</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>527 Valley View Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Yc</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u> d. STREET ADDRESS <u>527 Valley View Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry F. Frank</u>		4. DATE OF DEATH <u>October 4 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 9, 1896</u>	9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Official</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Helene D. Hoot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WNI</u>		16. SOCIAL SECURITY NO. <u>214-36-8550</u>	
17. INFORMANT <u>Carl Wallace</u>		Address <u>113 East Lake Avenue</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>470.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic hypertensive C.V.D.</u> DUE TO (c) <u>instant</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>instant</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>24 Oct., 1956</u> to <u>4 Oct., 1961</u> , that (I) (we) last saw the deceased alive on <u>4 Oct., 1961</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Muse Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Muse, M.D.</u>		22d. ADDRESS <u>2725 North Charles Street, Zone 18</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10-6-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.,</u>		25a. REC'D BY REGISTRAR <u>10 '61</u>	
ADDRESS <u>1050 York Road, Zone 4</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

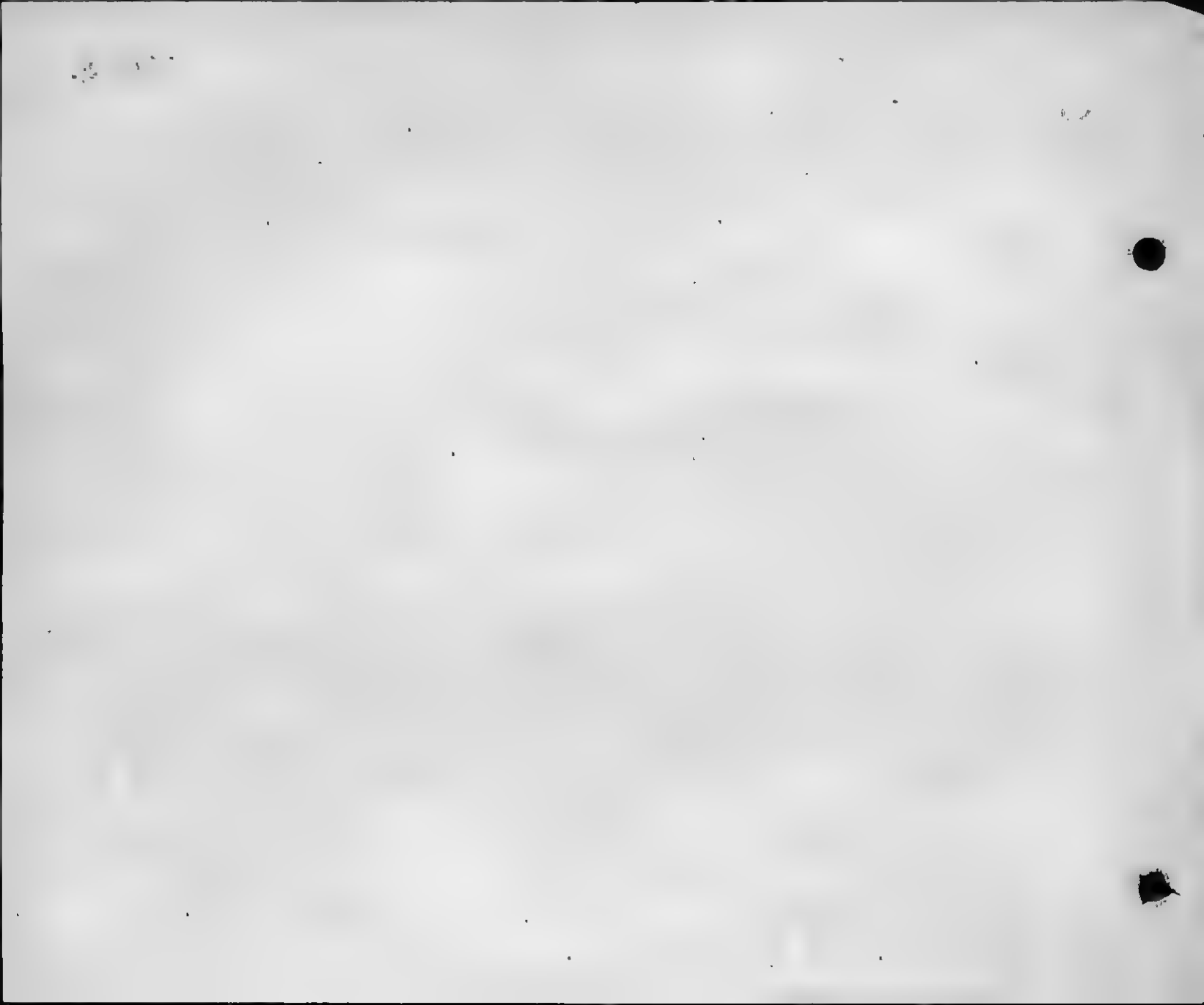
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11083

11073

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loch Raven Village</u> c. LENGTH OF STAY IN b1 <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1911 Redwood Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loch Raven Village</u> d. STREET ADDRESS <u>1911 Redwood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cesare</u> First Middle Last		4. DATE OF DEATH <u>Oct 7 1961</u> Month Day Year		5. SEX <u>male</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-23-1081</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stone Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Francesco Franzoni</u>		14. MOTHER'S MARIEN NAME <u>Rose (Unknown)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service)		16. SOCIAL SECURITY NO <u>219070614</u>		17. INFORMANT <u>Amelia C. Franzoni</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> 351X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>Arterio Sclerotic CVD.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>10 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from <u>May 1961</u> to <u>Oct 7, 1961</u> that (I) (the hospital) last saw the deceased alive on <u>Oct 6, 1961</u> and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Joseph F. Lipira M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/7/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. LIPIRA</u>		22d. ADDRESS <u>8400 Loch Raven Blvd. Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hargford Rd.</u>		25a. REC'D BY REGISTRAR <u>OCT 10 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

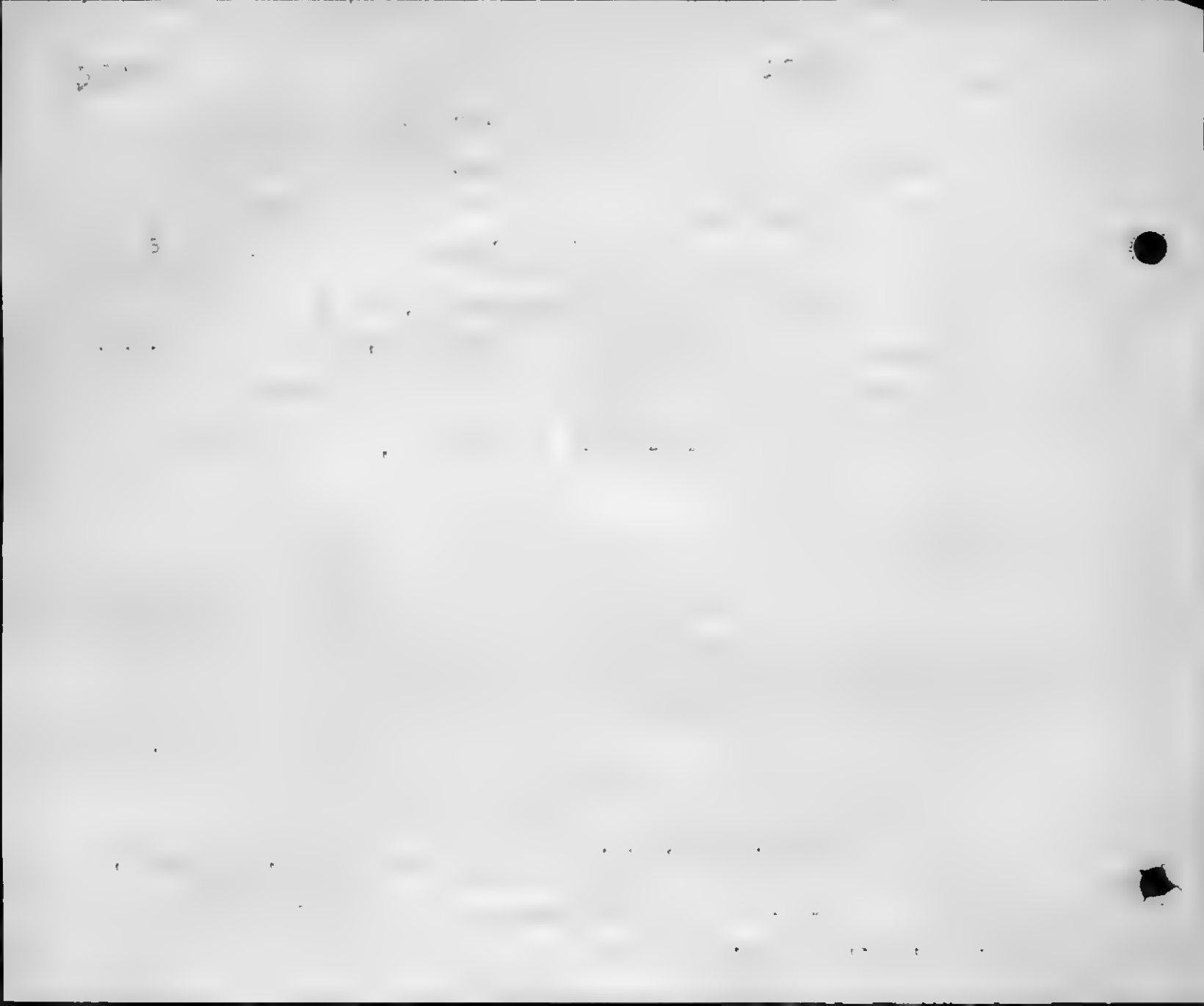
CERTIFICATE OF DEATH

11084

11074

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN lb Essex d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 162 Silver Lane Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex h. STREET ADDRESS 162 Silver Lane Road i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucy Virginia Gardner		4. DATE OF DEATH Month October Day 18 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 25, 1885	
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Muir		14. MOTHER'S MAIDEN NAME unknown Dennis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-8401-B	
17. INFORMANT John Gardner, 2428 East Fayette Street		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Subarachnoid Hemorrhage (b) Decomposed Anterior Subarachnoid Hemorrhage (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		21. I certify that (I) (this hospital) attended the deceased from March 1955 , to Oct 18, 1961 , that (I) (we) last saw the deceased alive on Oct 18, 1961 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.	
22a. SIGNATURE Robert J. Lyden		22b. DATE SIGNED Oct 24 '61	
22c. PHYSICIAN'S NAME (Type) Robert J. Lyden, M.D.		22d. ADDRESS 815 Eastern Avenue, Baltimore 2, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-21-61	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town or county) 3310 Taylor Avenue	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR OCT 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11085
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 15 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before death) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29 d. STREET ADDRESS 512 Glen Allen Drive e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TWITE WITZCH GEISLER		4. DATE OF DEATH Month October Day 5 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 24, 1895
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Explosives	
11. BIRTHPLACE (County & State, or foreign country) Allison Park, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Geisler		14. MOTHER'S MAIDEN NAME Elizabeth Deitz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 206-01-0038	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. ADDRESS Fort Howard Division	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS WITH JAUNDICE DUE TO (b) CARCINOMA OF URINARY BLADDER WITH METASTASIS TO PERIAORTIC NODES AND LIVER (c) ILEO-LOOP BLADDER CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. 181.0		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS UNKNOWN 15 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT INCLUDED IN PART I (a) 1. Operation - Total cystectomy with ileo-loop, 7/60. Operation 2. Exploratory Laparotomy, 7/17/61 - metastatic Carcinoma, liver & periaortic nodes.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) September 20, 1961, 1:55		20f. (City or town) (County) (State) October 5, 1961	
21. I certify that (X) (this hospital) attended the deceased from September 20, 1961 , to October 5, 1961 , that (X) (we) last saw the deceased alive on October 5, 1961 , and that death occurred at 1:55 M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 10/5/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10-5-61	
23c. NAME OF CEMETERY OR CREMATORY Mount Royal Cemetery		23d. LOCATION (City, town or county) (State) Glenshaw, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14		25a. REC'D BY REGISTRAR OCT 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			



T/890
2/17/1/25

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

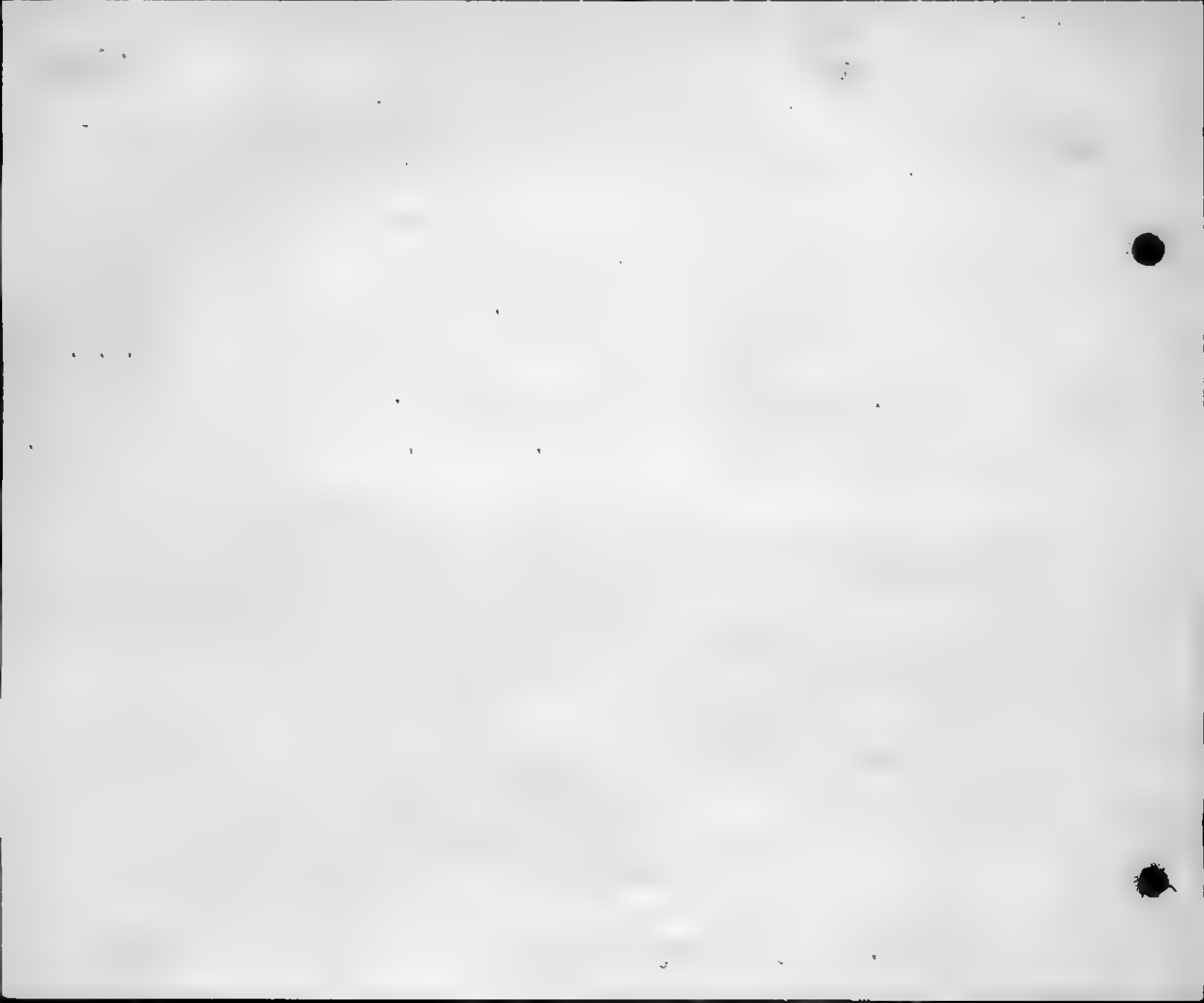
11087

11077

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8125 Dalesford Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>8125 Dalesford Road</u>	
3. NAME OF DECEASED (Type or print) <u>Miss Joan Eleanor German</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 11, 1946</u> 9. AGE (In years last birthday) <u>14</u> yrs. IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 14. MOTHER'S MAIDEN NAME <u>Nannie B. Matthews</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Mr. James H. German 8125 Dalesford Rd.</u> 16. SOCIAL SECURITY NO. <u>710X</u> 17. INFORMANT <u>Mr. James H. German 8125 Dalesford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Mitral Valvular Disease, Chronic</u> DUE TO <u>7 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>710X</u> DUE TO <u>7 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 7 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year <u>June 1954 to Oct 23, 1961</u> Hour a.m. <u>19</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Parkville</u> (County) <u>Baltimore</u> (State) <u>Md.</u>		21. I certify (I) (this hospital) attended the deceased from <u>June 1954 to Oct 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 20, 1961</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Joseph F. Chi Pira M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/24/61</u>		22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. CHIPIRA M.D.</u> 22d. ADDRESS <u>8400 Wood Haven Rd. K.O.B. 4/14</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11/27/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon Mem.</u> 23d. LOCATION (City, town or county) <u>BALTIMORE</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Hargford Road #14</u> 25a. REC'D BY REGISTRAR <u>OCT 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

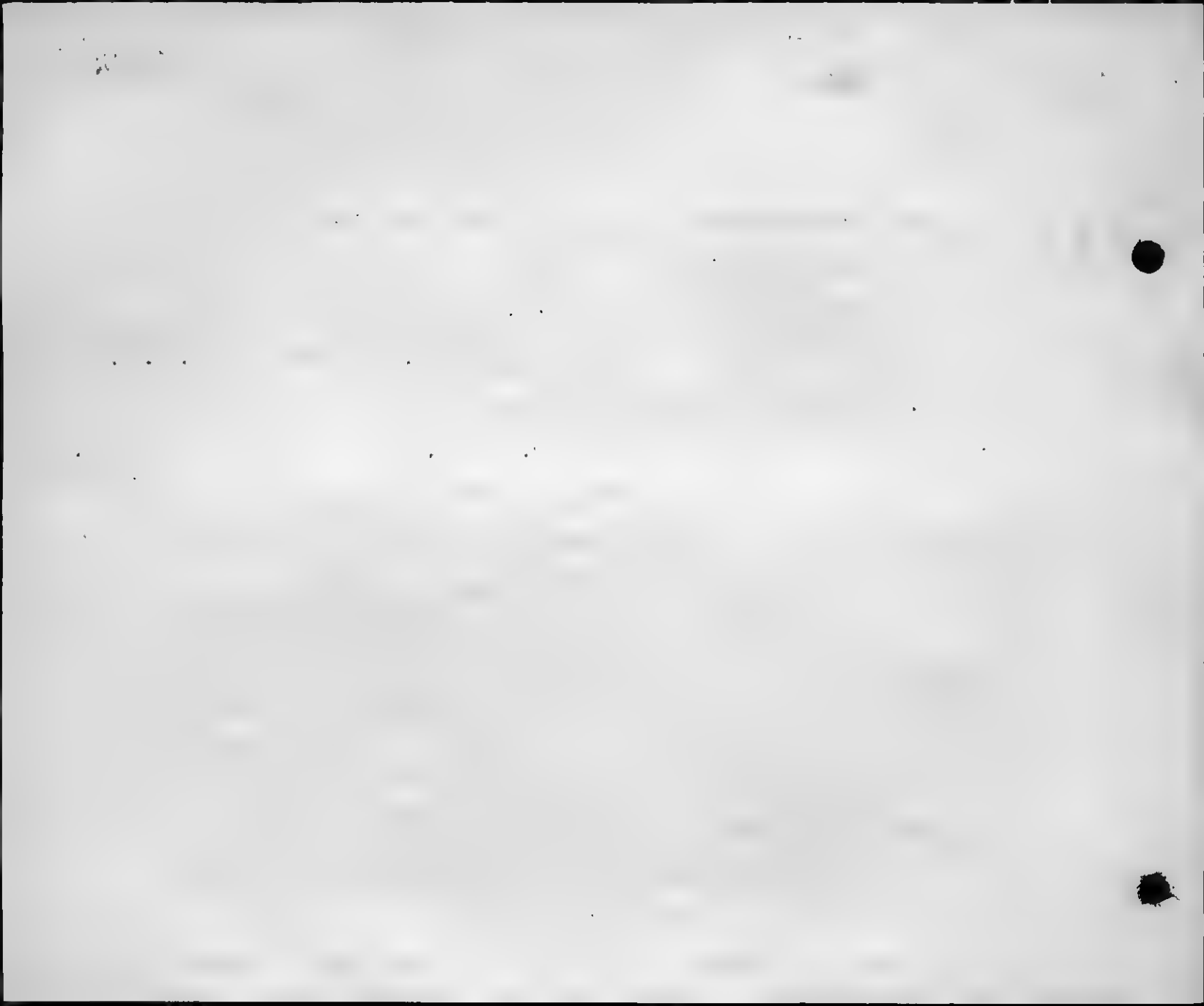
11088

11078

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 South Beechwood Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5 South Beechwood Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Bernard Riley Gilner</u>		4. DATE OF DEATH <u>October 28 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 24, 1906</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photo Engraver (Retail)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>			
13. FATHER'S NAME <u>Harry J. Gilner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Callahan</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Mary G. Ellard-5 South Beechwood Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Parkinson's Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jan</u>			
20f. (City or town) <u>Baltimore</u>		(County) <u>Baltimore</u>		(State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961</u> to <u>10/28, 1961</u> , that (I) (no) last saw the deceased alive on <u>10/1</u> 19 <u>61</u> , and that death occurred at <u>6A</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>James J. Nolan</u>		22b. DATE SIGNED <u>10/28/61</u>		22c. PHYSICIAN'S NAME (Type) <u>J. J. NOLAN MD</u>			
22d. ADDRESS <u>1 Mallon Hill Ave Baltimore 29, Md.</u>		22e. REC'D BY REGISTRAR <u>Charles S. Hanna</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>			
23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>		23e. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. McKenna & Sons</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



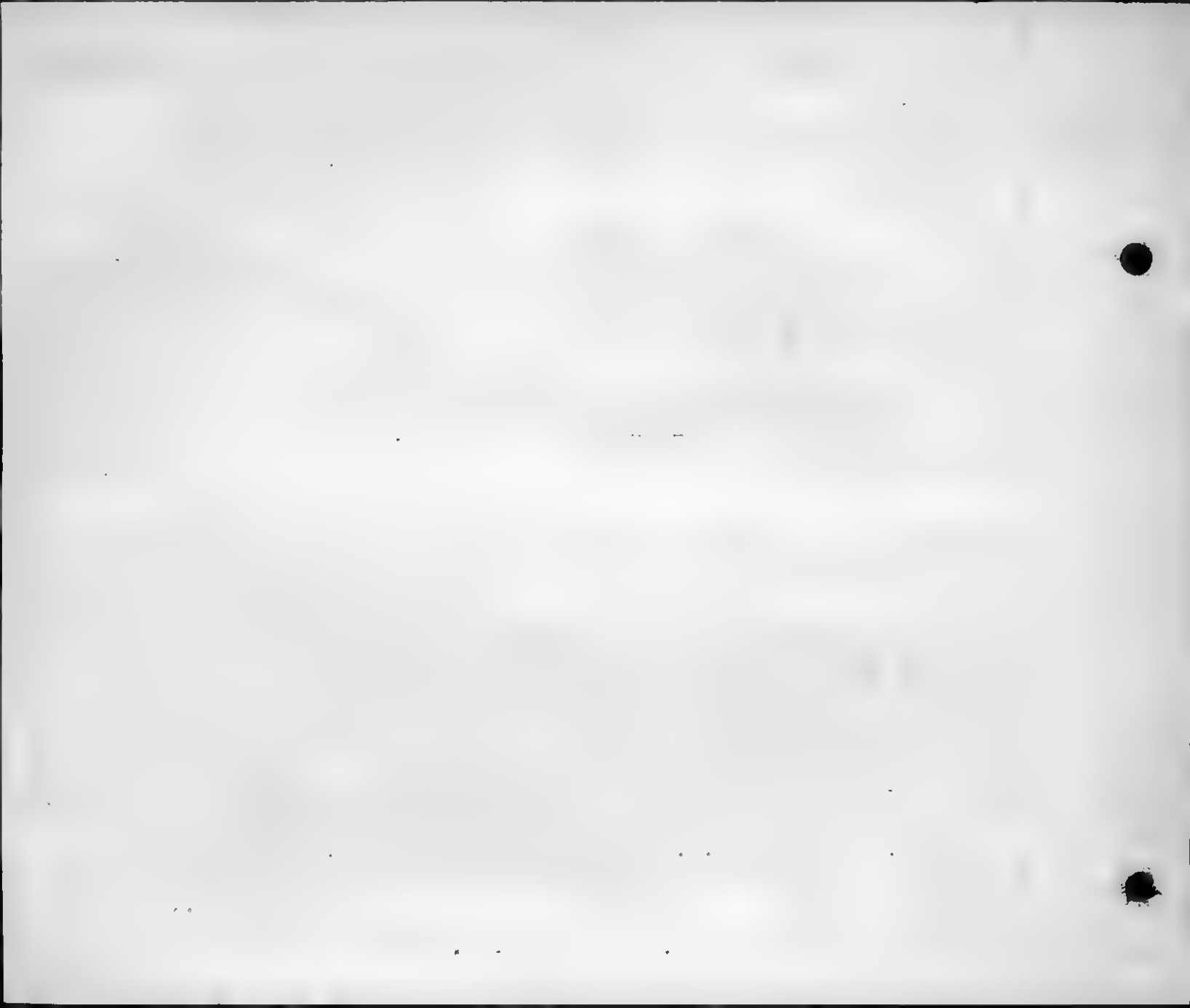
1
4
M
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11089 CERTIFICATE OF DEATH

Reg. Dist. No. 11079

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN lb 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3420 Dunhaven Road				d. STREET ADDRESS 3420 Dunhaven Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL LEE GODSEY				4. DATE OF DEATH Month Day Year October 1st, 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 11, 1899	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1st Helper Open Hearth Steel				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Godsey				14. MOTHER'S MAIDEN NAME Mary Wommack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI				16. SOCIAL SECURITY NO 214-05-9313		17. INFORMANT Margaret L. Godsey Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THROAT 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June, 1961 to 1 October, 1961 , that I last saw the deceased alive on 1 October, 1961 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore 22, Maryland DATE SIGNED 10/3/61							
ACTUAL SIGNATURE W.E. Baermann M.D. 3401 Dundalk Avenue							
PHYSICIAN'S NAME (Type) W.E. Baermann, M.D.				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REGISTAR DATE OCT 6 '61		24b. REGISTRAR'S SIGNATURE Walter Brooks Bradley	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11090

11080

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write street and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1200 Harwell Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1200 Harwell Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna I. Grafton</u> First Middle Last 4. SEX <u>F.</u> 5. COLOR OR RACE <u>W.</u> 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH <u>DEC. 28, 1907</u> 8. AGE (in years last birthday) <u>53</u> yrs. 9. IF UNDER 1 YEAR: Months <u>0</u> Days <u>25</u> Hours <u>6</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR, U. S. GOV'T</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN F. FABIAN</u>		14. MOTHER'S MAIDEN NAME <u>ROSE DIEGEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>RD.</u>	
17. INFORMANT <u>MR. NATHAN GRAFTON, 1200 HARWELL RD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ovarian Carcinoma</u> 1750 DUE TO <u>With Metastases</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>about 10 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15, 1961</u> to <u>Oct 25, 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 25, 1961</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M Paul Beyerly</u> M.D.		22b. DATE SIGNED <u>10/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M Paul Beyerly</u>		22d. ADDRESS <u>5820 York Rd Balto Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEMET</u>		23d. LOCATION (City, town or county) <u>BALTO. MD.</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WILFRED F. D. 4101 EDMONDSON AVE</u>		25a. REC'D BY REGISTRAR <u>Oct 26 8 56 '61</u> 25b. REGISTRAR'S SIGNATURE <u>C. J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11081

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 302, Chesapeake Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IDA Marie Graham				4. DATE OF DEATH 10 29 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/1889	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Lewis				14. MOTHER'S MAIDEN NAME Dora Luers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Lawrence Zorn, nephew, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Generalized Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Diabetes Mellitus (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 30 min 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				DATE SIGNED 10-10-61			
EXAMINER'S NAME (Type) Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/61		22c. NAME OF CEMETERY OR CREMATORY Schwartz Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Brehms Lane				24a. REC'D BY REGISTRAR 10-11-61		24b. REGISTRAR'S SIGNATURE John A. Huns	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

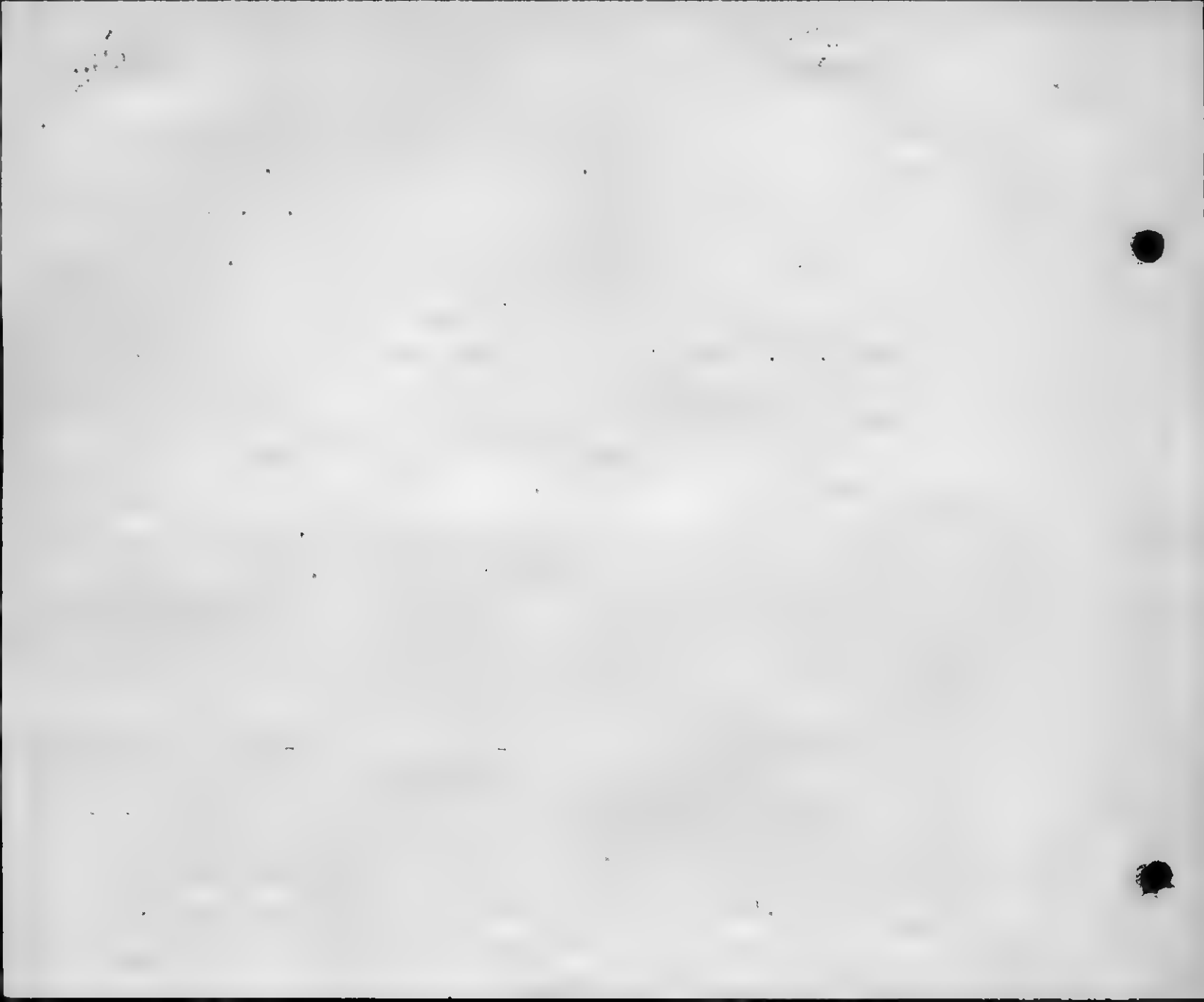
11092

11082

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>1 Da.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md.</u> d. STREET ADDRESS <u>303 First Ave., S. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Frank</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-1878</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Const. Eng.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cummings & Hent</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>215 05 2614</u>		17. INFORMANT <u>Records: Spring Grove State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia.</u> (b) <u>Arteriosclerotic cardiovascular disease.</u> (c) <u>Arteriosclerosis, generalized, severe.</u> PART II. OTHER SIGNIF. COND'TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u> </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10-26-61 11:30</u> to <u>10-27-61</u> , 19 <u> </u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-27-61</u> 19 <u> </u> , and that death occurred at <u>2</u> a.m. from the causes and on the date stated above.															
22a. SIGNATURE <u>Stella Wachsler</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10-27-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>30th Oct. '61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		23d. LOCATION (City, town or county) <u>Glen Burnie, Md.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard P. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1 & 14 filed 11/2/61 jwk

11093

CERTIFICATE OF DEATH

Reg. Dist. No. 11083

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cutonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>the House in Pines</u>		e. STREET ADDRESS <u>6817 Georgia Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>GREENBERG</u> Last <u>GREENBERG</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>78</u> yrs
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Greenberg</u>		14. MOTHER'S MAIDEN NAME <u>Soldie unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Ray Greenberg - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4 <u> </u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-6-1961</u> to <u>10-30-1961</u> , that I last saw the deceased alive on <u>10-29-1961</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		M.D. <u>6209 Frederick Ave</u> DATE SIGNED <u>10-30-61</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, MD</u>		<u>Baltimore - 28, 2nd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10-31-61</u>	<u>Arlington</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Eutan Place</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

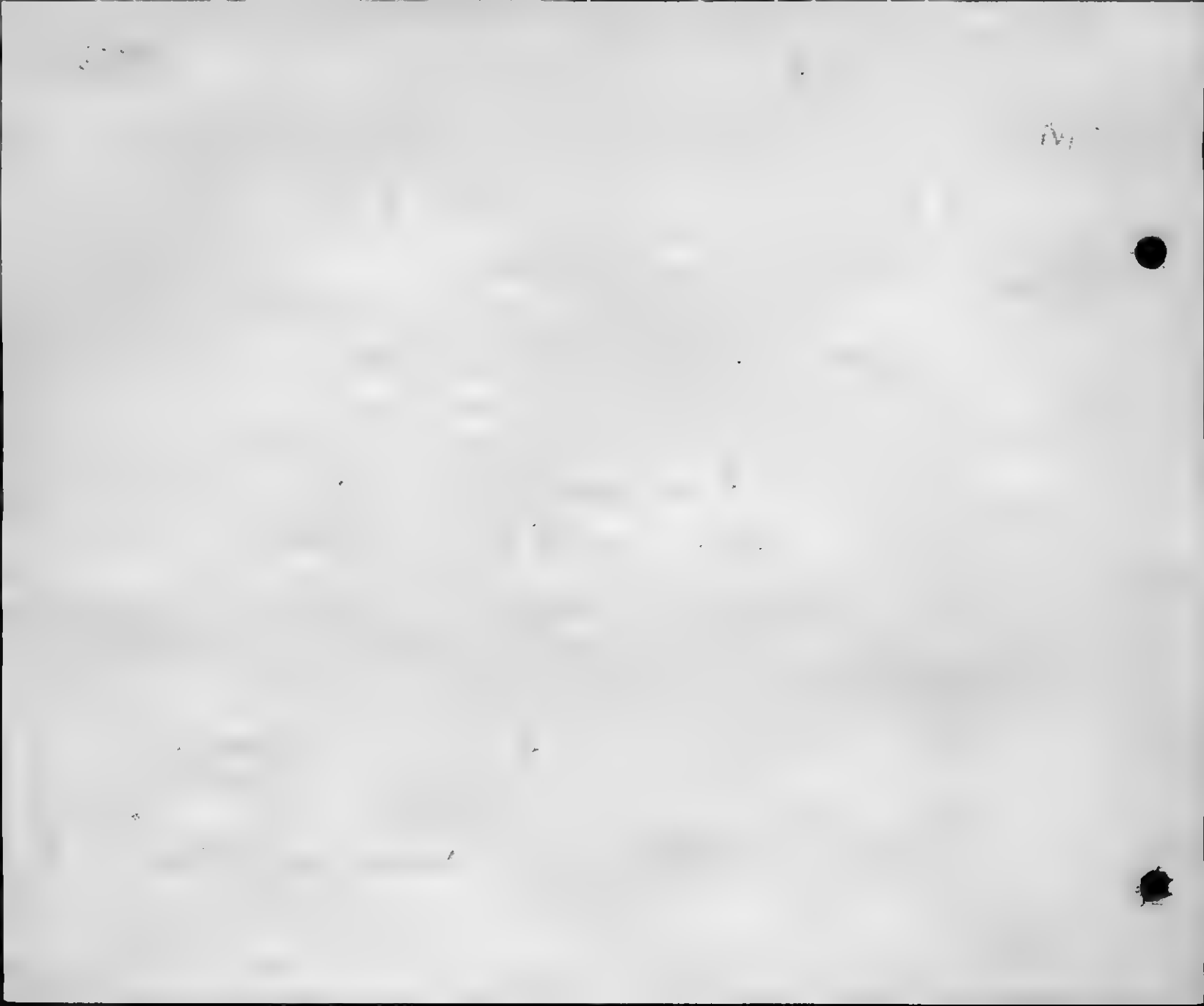
VR A15 (4)
15M 9/60

11094

11084

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

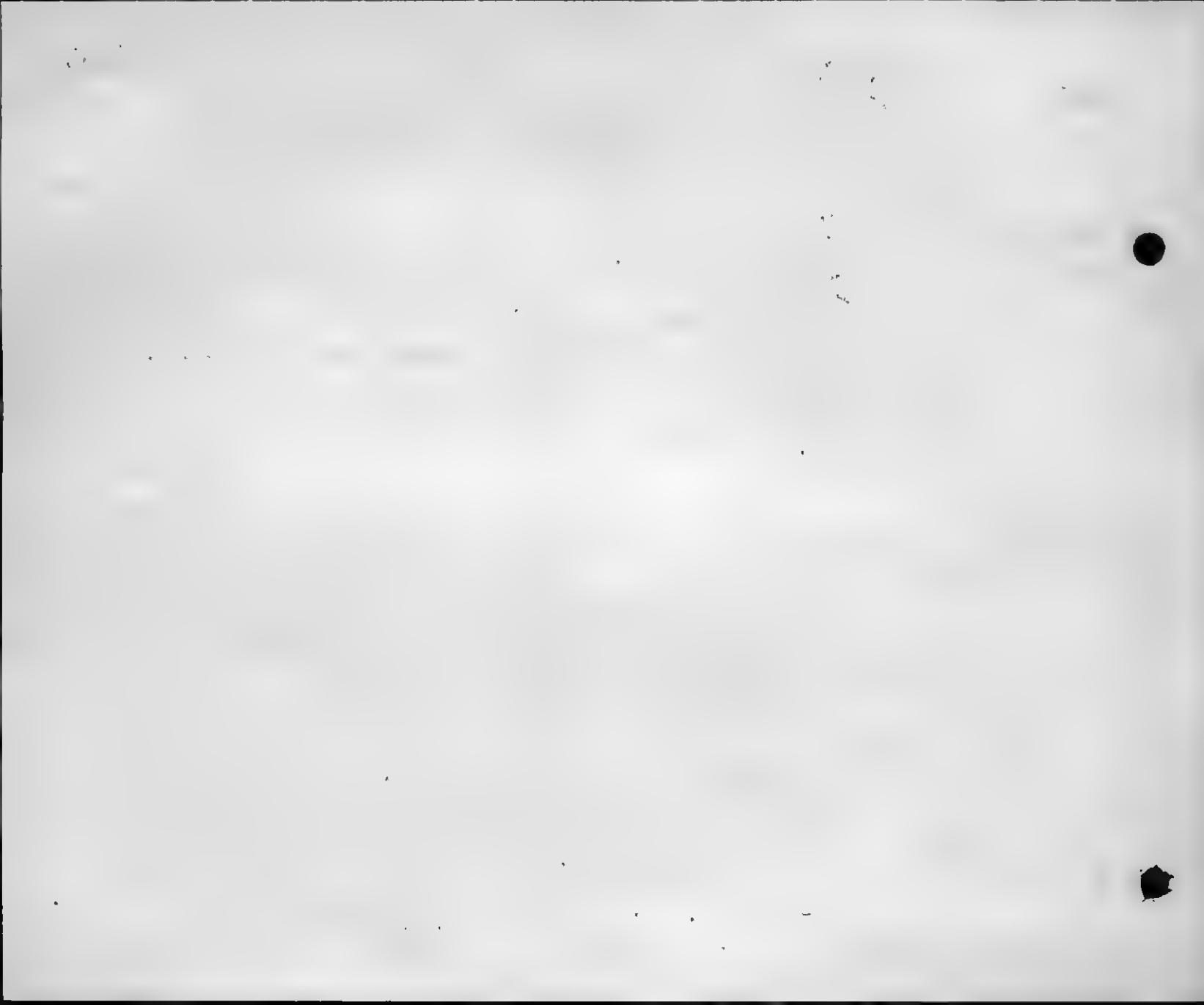
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 29</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>434 S. Augusta Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in Pines</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>William T. Grindell</u>		4. DATE OF DEATH <u>Oct. 29 1961</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22, 73</u>	
9. AGE (in years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linotype of Sun Paper</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Grindell</u>		14. MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Albert Atkinson</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> 422 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> (c) <u>stating the underlying cause last.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>15 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-4-</u> 19 <u>60</u> to <u>10-29-</u> 19 <u>61</u> , that (I) (two) last saw the deceased alive on <u>10-28-</u> 19 <u>61</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u>10/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher M.D.</u>		22d. ADDRESS <u>6299 Frederick Ave., Baltimore 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>Balt. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Macdonald & Son</u>		24. ADDRESS <u>28</u>	
25a. REC'D BY REGISTRAR DATE <u>NOV 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11095											
11085											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>						c. LENGTH OF STAY IN 1b <u>7yr8mth3dys</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>						d. STREET ADDRESS <u>200 East Fort Avenue</u>					
3. NAME OF DECEASED (Type or print) <u>Charles I. Gude</u>						4. DATE OF DEATH <u>October 8 1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17, 1915</u>		9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shipyard worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>shipyard</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, Baltimore</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Gude</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Bachman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown No.</u>						16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>											
491 X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (if this hospital) attended the deceased from <u>Feb. 5 1954</u> to <u>Oct. 8 1961</u> , that (we) last saw the deceased alive on <u>Oct. 8 1961</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Stella Wachsler, M. D.</u>						22b. DATE SIGNED <u>10-9-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>						22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		23d. LOCATION (City, town or county) <u>5712 S'Donnell St Balto.</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Ziller</u>						ADDRESS <u>901 S Conkling St Balto., Md.</u>		25a. REC'D BY REGISTRAR <u>Oct 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

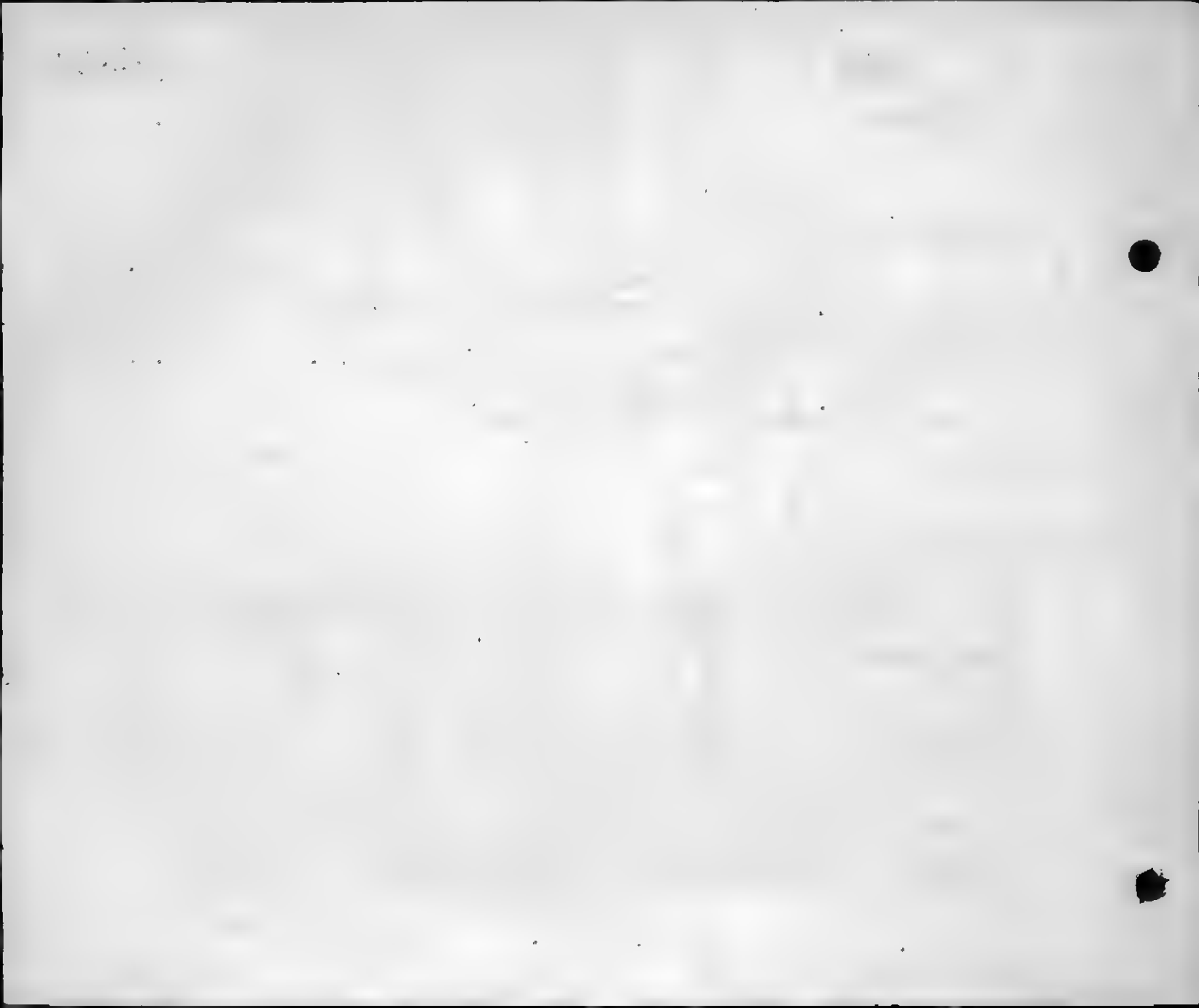
11086

11095

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dundalk Balto.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dundalk</u>	
d. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Guin</u> Last		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joe Guin</u>		4. DATE OF DEATH Month <u>October</u> Day <u>3rd</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 10-68</u>
9. AGE (in years last birthday) <u>53</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Union Co. N.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George W. Guin</u>		14. MOTHER'S MAIDEN NAME <u>Renie White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Effie Guin</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812X</u> DUE TO <u>Crushing injury to chest and upper abdomen</u> Conditions, if any, which gave rise to immediate cause (b) <u>upper abdomen</u> (c) <u>upper abdomen</u> DUE TO <u>upper abdomen</u> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) <u>Truck backed over him.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2</u> Hour <u>10-3</u> <u>1961</u> a.m. <u>10-3</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Dundalk Balto Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/7/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Caryer Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy N. Wilson</u>		24a. REC'D BY REGISTRAR <u>Oct 11 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>		DATE SIGNED <u>10/7/61</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

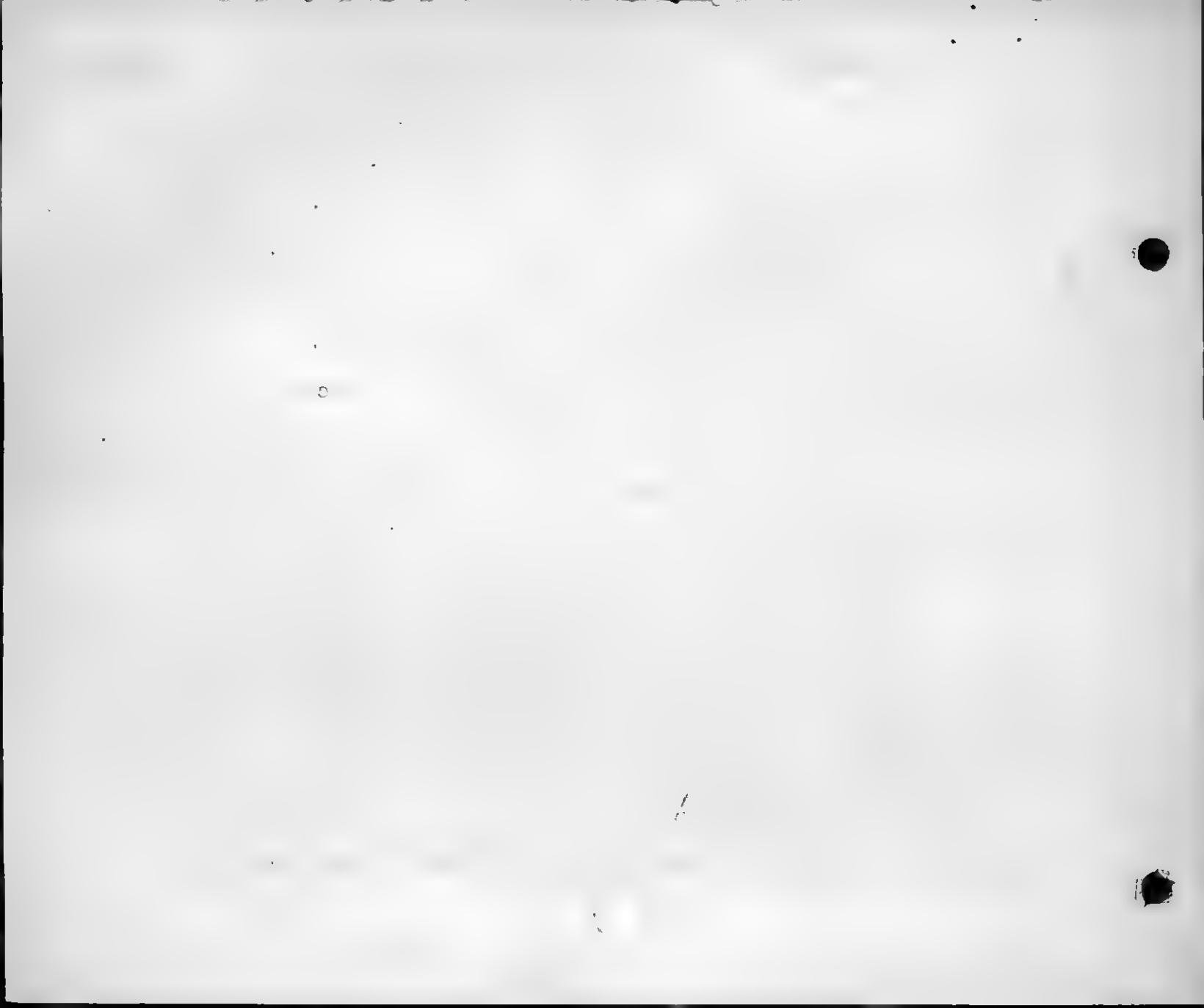
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

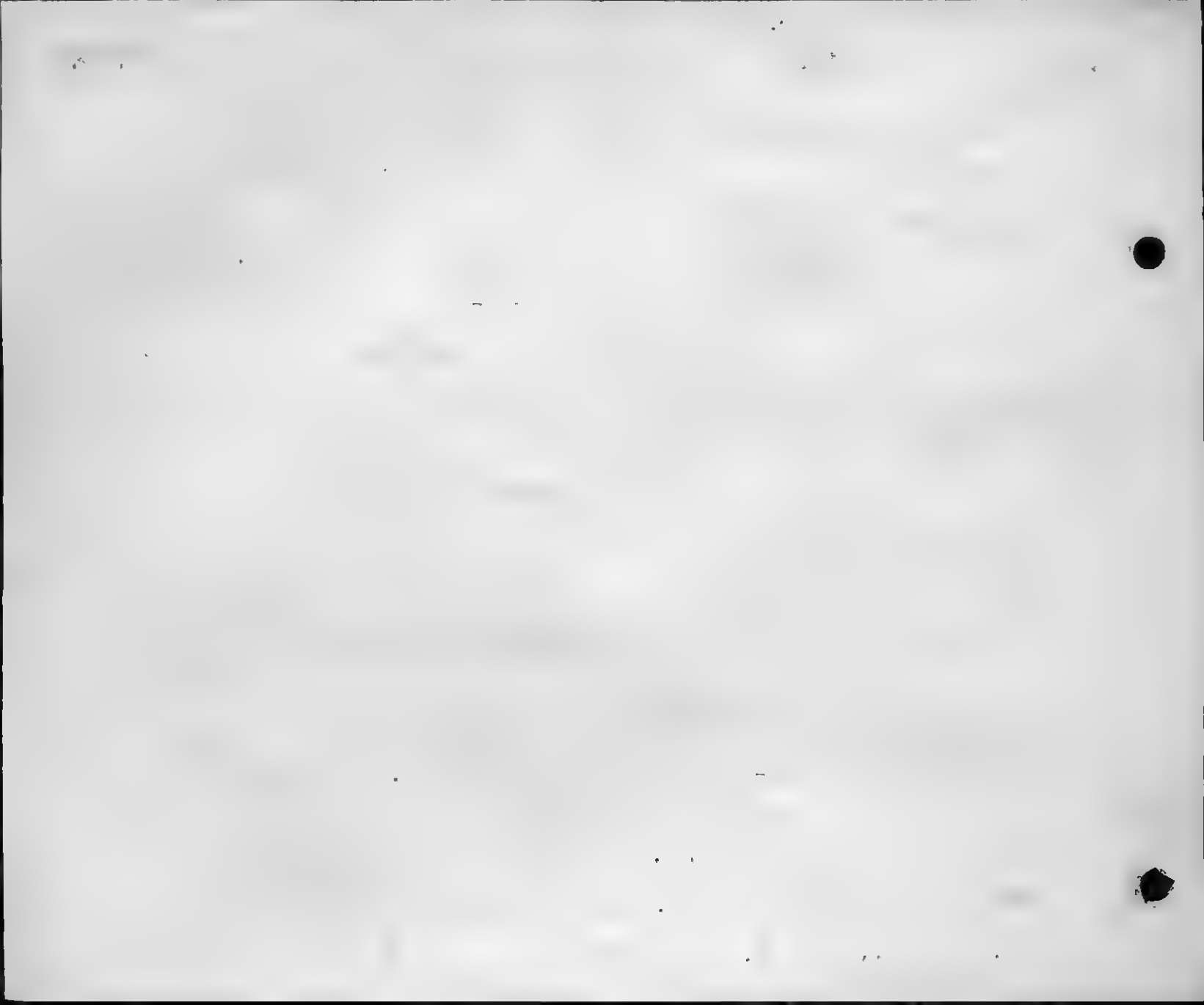
CERTIFICATE OF DEATH

11097

11087

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		2. USUAL RESIDENCE (Where deceased lived in institution: Residence before admission) a. STATE MARYLAND b. COUNTY Penn. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gettysburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1823 Mayfield Ave		d. STREET ADDRESS 134 Hanover St.	
3. NAME OF DECEASED (Type or print) MINNIE A GUTMANN First Middle Last		4. DATE OF DEATH Oct. 1, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1881 yrs. Months Days Hours Min
9. AGE (In years last birthday) 80 1/2		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Andreas, Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elias Mantz		14. MOTHER'S MAIDEN NAME Sarah Lechleitner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT John E. Gutmann, 1823 Mayfield Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE (c) HYPERTENSION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 Sept 1961 to 30 Sept 1961 , that (I) (we) last saw the deceased alive on 30 Sept 1961 , and that death occurred at HP M, from the causes and on the date stated above.			
22a. SIGNATURE George E. Groleau M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George E. Groleau		22d. ADDRESS 5608 Main Street, Elkridge, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/61	
23c. NAME OF CEMETERY OR CREMATORY New Morivia		23d. LOCATION (City, town, or county) (State) Emmaus, Penn	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave		25a. REC'D BY REGISTRAR OCT 3 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

11099

11089

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bent Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>11904 Kenton Road, Reisterstown, Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Esmereldo</u> Middle <u>Halzapfil</u> Last <u>Halzapfil</u>		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>81</u> yrs. <u>81</u> yrs. <u>81</u> yrs.			
9. AGE (In years last birthday) <u>81</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>		13. FATHER'S NAME <u>Francis Marion Hale</u> 14. MOTHER'S MAIDEN NAME <u>Eichelberger</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u> 17. INFORMANT <u>Arthur E. Hager</u> Address <u>11904 Kenton Road, Reisterstown, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - aspiration</u> (b) <u>Arteriosclerosis</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Reisterstown</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>Maryland</u>			
21. I certify that (I) (this hospital) attended the deceased from July 1961 to October 22, 1961, that (I) (we) last saw the deceased alive on October 20, 1961, and that death occurred at 10:00 AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clarence E. Williams</u> M.D.		22b. DATE SIGNED <u>October 27, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Clarence E. Williams</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>11/25/61 BURIAL</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL</u>		23d. LOCATION (City, town or county) <u>HAGERSTOWN MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Hager</u>		25. REC'D BY REGISTRAR <u>OCT 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hager</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1001 McQueen St.
Rocky,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

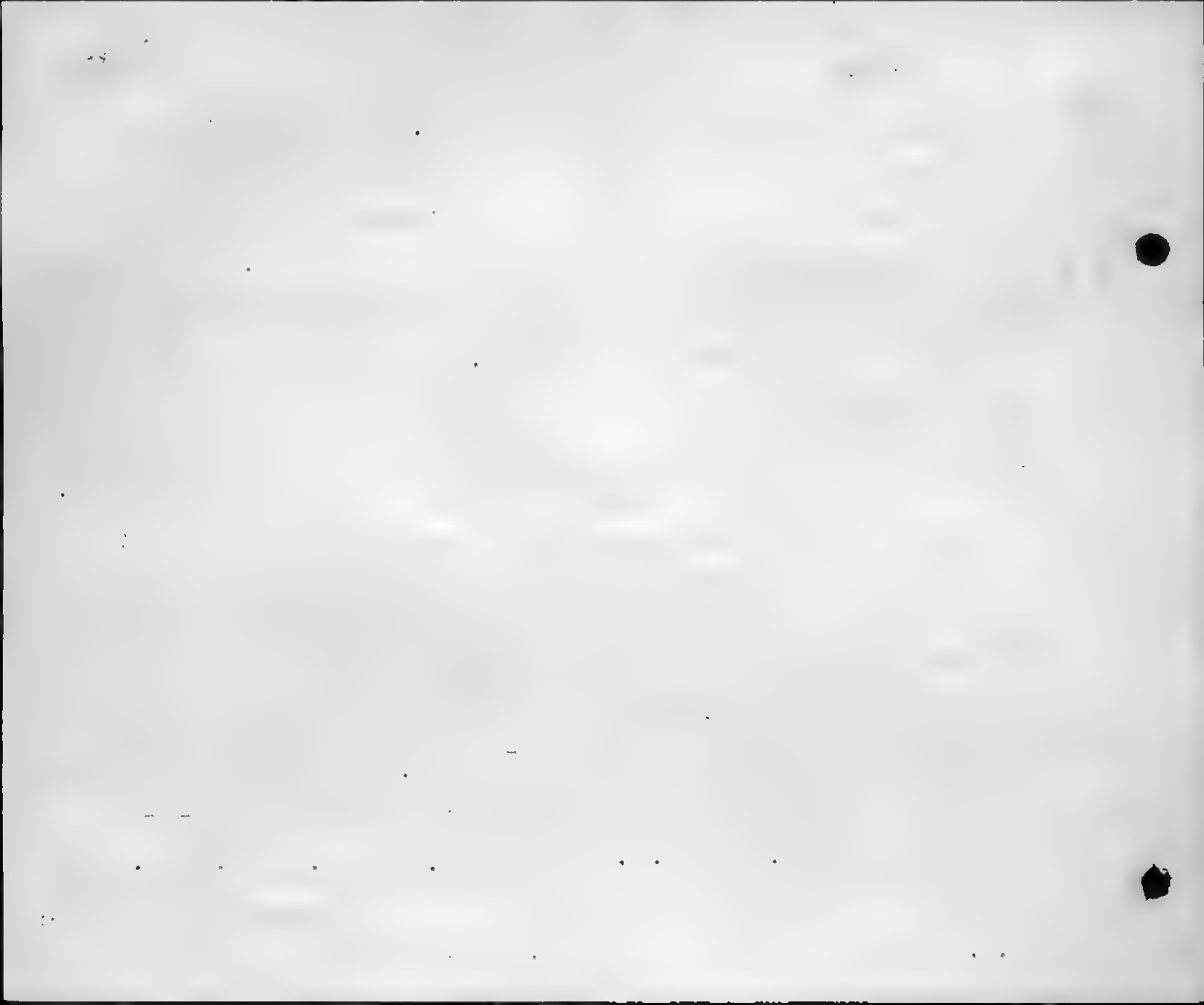
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11100

11090

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>"Withywood"</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u> d. STREET ADDRESS <u>"Withywood"</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Luck Hammond</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1905</u> Age (in years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Preston Luck</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Ashton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hall Hammond</u>	
17. INFORMATION <u>Above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: MED. IATE CAUSE (a) <u>Myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic heart disease and hypertension</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-29-43</u> , 19... to death... 19..., that (I) (we) last saw the deceased alive on <u>10-10-61</u> , 19..., and that death occurred at <u>11:30 a/m</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Warde B. Allan, M.D.</u>		22b. DATE SIGNED <u>10-17-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Warde B. Allan, M.D.</u>		22d. ADDRESS <u>6 E. Eager St., Balto. 2, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-18-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>		25. REC'D BY REGISTRAR <u>OCT 20 '61</u>	
25a. ADDRESS <u>4905 York Rd. Balto.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11101

11091

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Overlea</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5611 East Ave</u>				d. STREET ADDRESS <u>1 5611 East Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donna</u> Middle <u>Camilla</u> Last <u>Harant</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 1947</u>		9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis C. Harant</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Chaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Francis Charant</u> Address <u>5611 East Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> <u>191X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGENITAL CEREBRAL MALFORMATION</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR. 15 1948</u> to <u>OCT. 2 1961</u> , that (I) (we) last saw the deceased alive on <u>10/2 1961</u> , and that death occurred at <u>2:18 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>John W. Machen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>JOHN W. MACHEN</u>				22d. ADDRESS <u>M.D. 6331 BELAIR ROAD (6)</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-5-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		23d. LOCATION (City, town, or county) <u>Belair Rd Balto Md</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chippel Bros. 7110 Belair Rd</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

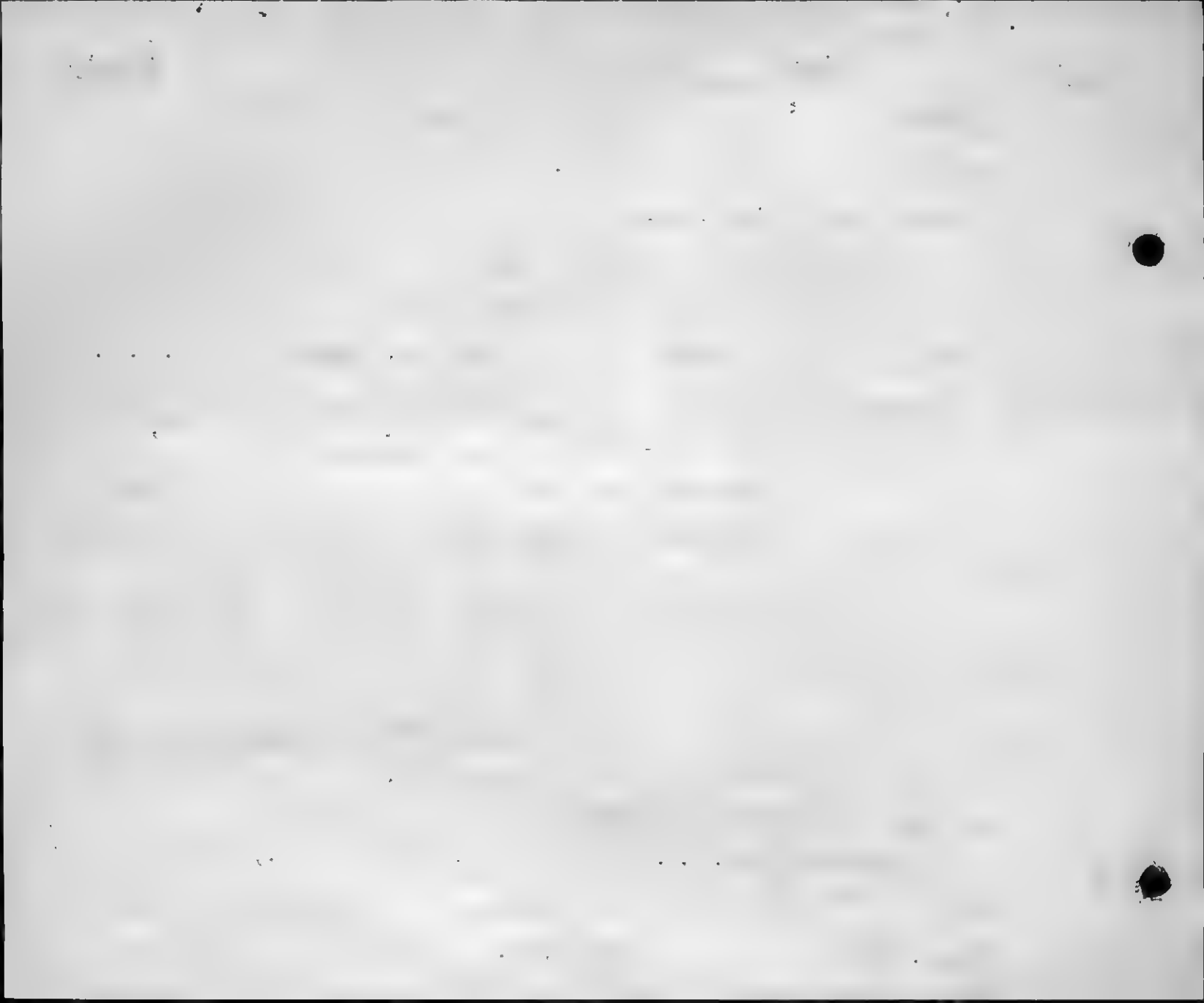
CERTIFICATE OF DEATH

11102

11092

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 9 Hrs. 45 M. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellevue d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HOWARD First Middle Last		4. DATE OF DEATH Month October Day 4 Year 1961		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 10a. FATHER'S NAME Perry Haskins		9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR: Months 4 Days 19 IF UNDER 24 HRS.: Hours 45 Min. 15		11. BIRTHPLACE (County & State, or foreign country) Deep Neck, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Perry Haskins 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 145-14-3767		17. INFORMATION Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LEFT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BILATERAL PULMONARY EMPHYSEMA DUE TO (c) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH 1 DAY + UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:40 AM p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore (County) MD. (State) MD.			
21. I certify that he (this hospital) attended the deceased from October 4, 1961 to October 4, 1961 , that he (we) last saw the deceased alive on October 4, 1961 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION		22b. DATE SIGNED 10/5/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 7-1961		23c. NAME OF CEMETERY OR CREMATORY Royal Oak Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiells		ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR OCT 9 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

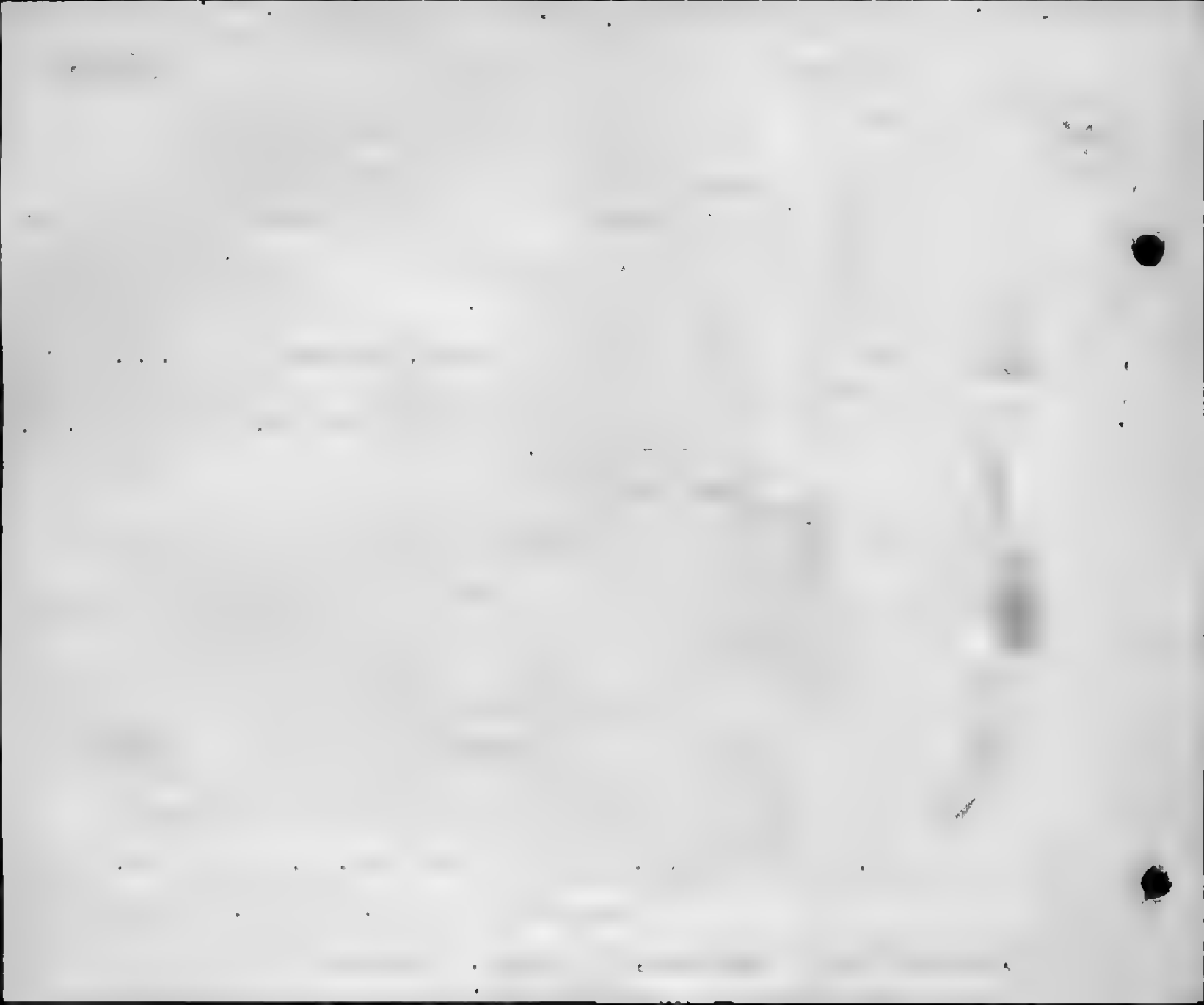
CERTIFICATE OF DEATH

11103

Item 2-b, Film 6299 11/6/61 iwk

11093

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN lb <u>66 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1718 Abbottston Street</u> d. STREET ADDRESS <u>1718 Abbottston Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM A. HEATLEY</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1889</u>
9. AGE (In years last birthday) <u>72 yrs.</u>		10. IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roller Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Passiac, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Heatley</u>		14. MOTHER'S MAIDEN NAME <u>Mary McShane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>213-03-4977</u>	
17. INFORMANT <u>Clinical Records, VAH, Baltimore, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>DUE TO</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (If at this hospital) attended the deceased from <u>August 23, 1961</u> to <u>October 28, 1961</u> , that (we) saw the deceased alive on <u>October 28, 1961</u> , and that death occurred at <u>10PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. Lawrence Rubin, M.D.</u>		22b. DATE SIGNED <u>10/29/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. LAWRENCE RUBIN, M.D.</u>		22d. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIV.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/31/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>E. North Ave. & Rose Sts</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Melville Jenkins</u>		25a. REC'D BY REGISTRAR <u>Oct 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>		25c. ADDRESS <u>Baltimore, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

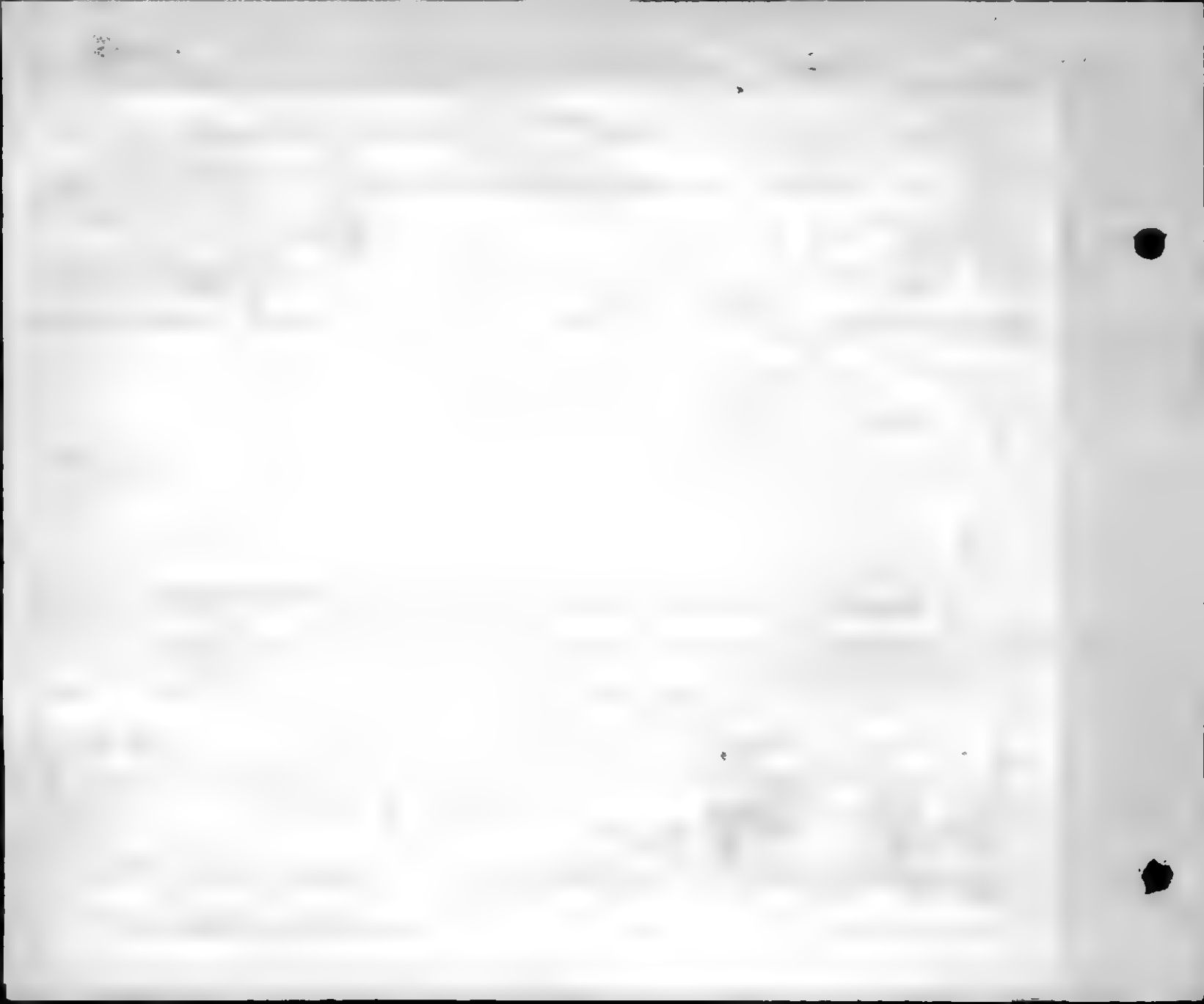
11104

CERTIFICATE OF DEATH

11094

1. NAME OF DECEASED (Type or Print) WILLIAM JOHN HEBNER		2. DATE OF DEATH OCTOBER 13, 1961	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Baltimore City</i> FULL NAME OF HOSPITAL OR INSTITUTION 4234 BELMAR AVENUE (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE 6 (If outside city limits, write RURAL and give township) D. STREET ADDRESS 4234 BELMAR AVENUE (If rural, give location)	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE 26, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER MAKER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED 34 YRS.	9. AGE (In years last birthday) 94
13. FATHER'S NAME CONRAD HEBNER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WILLIAM A. HEBNER		ADDRESS 4234 BELMAR AVE.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) MYOCARDIAL INFARCTION DUE TO ARTERIO-SCLEROTIC HEART DISEASE DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 10 YEARS			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
22. I certify that (I) (this hospital) attended the deceased from May 5 1961 to Oct. 13 1961 , that (I) (we) last saw the deceased alive on Oct. 13 1961 and that in (my) (our) opinion death occurred at 11 P. M. from the causes and on the date stated above.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. SIGNATURE <i>Adam J. Lewis</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS 6232 BELAIR ROAD	23c. DATE SIGNED OCT. 16, 1961
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 10/17/61	24c. NAME OF CEMETERY OR CREMATORY MOUNT CARMEL CEMETERY	24d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
25a. DATE OF BY HEALTH DEPT. OCT 18 1961		25b. NAME OF REGISTRAR <i>Arthur J. Lewis</i>	
25c. FUNERAL DIRECTOR HENRY SANDER & SONS INC.		ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11105

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

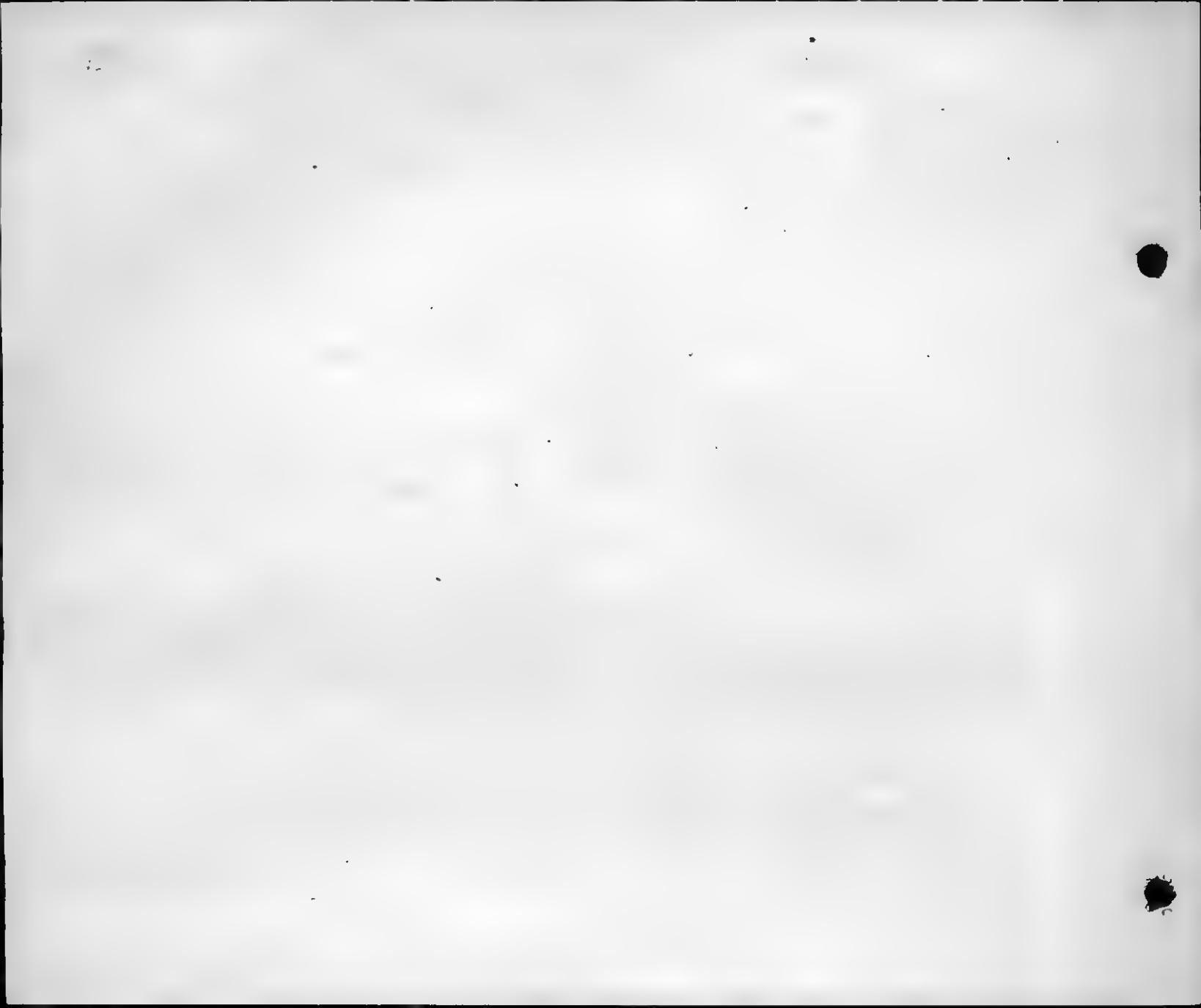
CERTIFICATE OF DEATH

11095

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>		d. STREET ADDRESS <u>1807 Frederick Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caten Ridge Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First <u>Hendricks</u> Middle <u></u> Last		4. DATE OF DEATH <u>October 20, 1961</u> Month <u>October</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Un Known Cook</u>		14. MOTHER'S MAIDEN NAME <u>Un Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Martin Hendricks</u>		Address <u>1935 Grinnalds Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebellar Thrombosis</u> DUE TO (b) <u>Cerebellar Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis generalis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2:30</u> <u>19</u> <u>8</u> to <u>10:20</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>10:20</u> <u>1961</u> , and that death occurred at <u>9:45</u> <u>M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John P. Urlock Jr.</u>		22b. DATE SIGNED <u>10-24-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR</u>		22d. ADDRESS <u>1227 WASH BLVD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>GO. L. Schwab</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kneiss</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>		DATE <u>OCT 24 '61</u>	

(M)

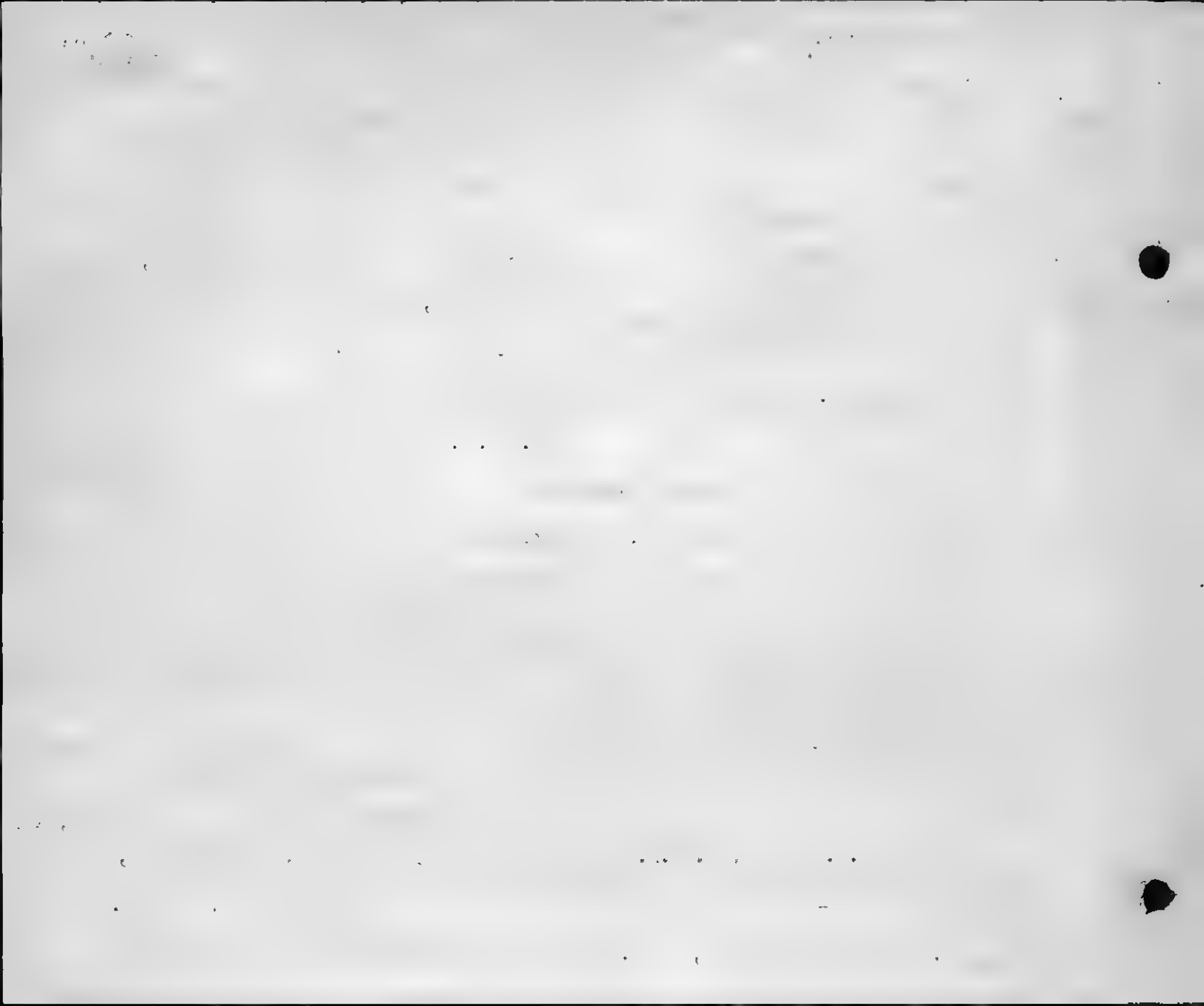
(I)



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11106
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11096

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Presbyterian Home		d. STREET ADDRESS 4028 Falls Road	
3. NAME OF DECEASED (Type or print) Josephine		4. DATE OF DEATH October 9, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1874
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months 3 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY None	
13. FATHER'S NAME Daniel B. Hendrix		14. MOTHER'S MAIDEN NAME Mary Agnes Fulton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. T.E. Elliott, Presbyterian Home		Address Presbyterian Home	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the breast		INTERVAL BETWEEN ONSET AND DEATH 10 min years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from January 1958 to October 9, 1961 , that (I) (we) last saw the deceased alive on October 5, 1961 , and that death occurred at 9:15 pm from the causes and on the date stated above.			
22a. SIGNATURE S.J. Venable, Jr. M.D.		22b. DATE SIGNED Oct 10, 1961	
22c. PHYSICIAN'S NAME (Type) S.J. Venable, Jr. M.D.		22d. ADDRESS 7215 York Road, Baltimore 12, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-61	
23c. NAME OF CEMETERY OR CREMATORY Stewartstown		23d. LOCATION (City, town or county) (State) Stewartstown, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		25. REC'D BY REGISTRAR Oct 13 '61	
25a. REGISTRAR'S SIGNATURE Arthur L. Hines		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



CERTIFICATE OF DEATH

Reg. Dist. No.

11097

11107

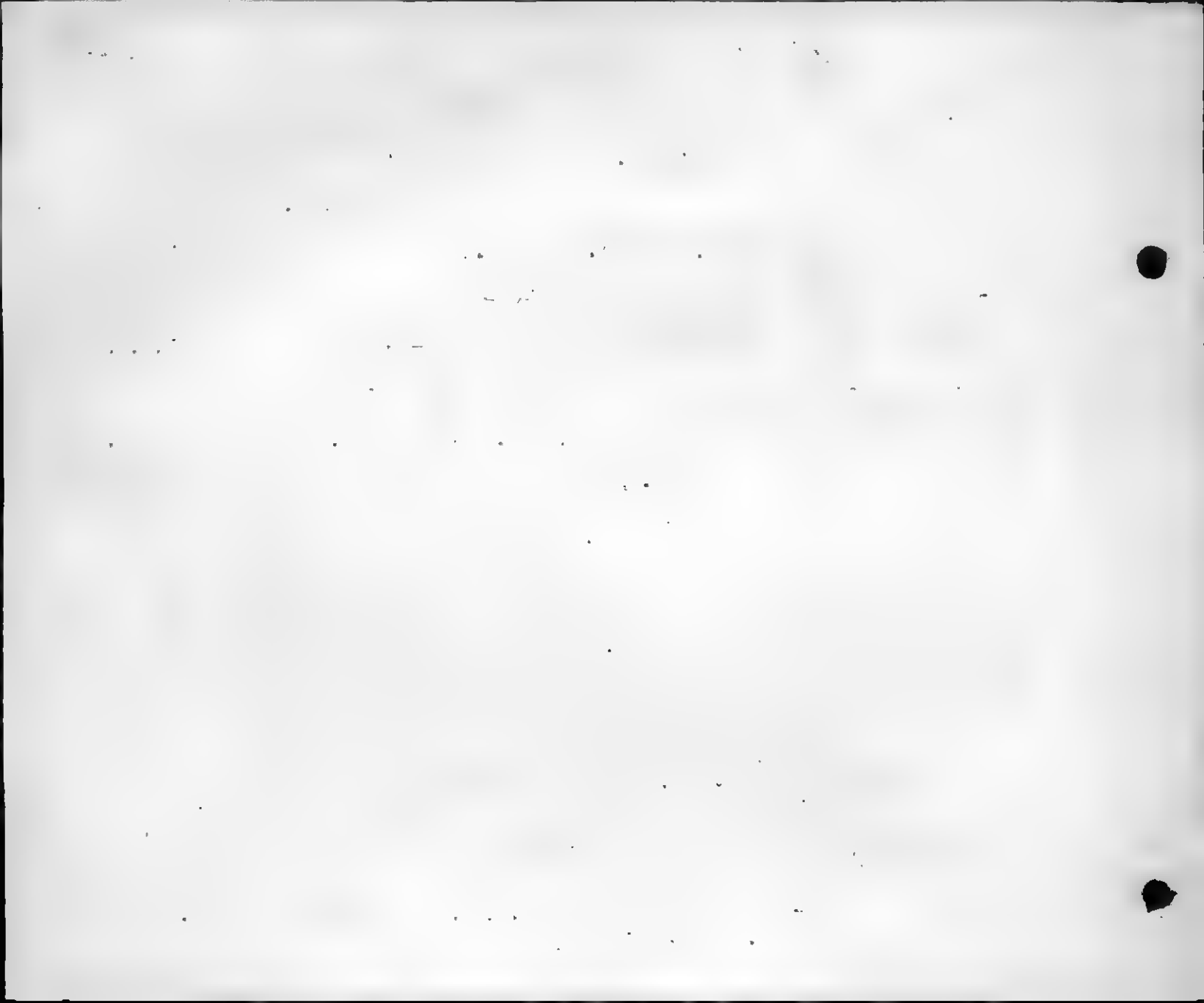
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5808 Westwood Ave		d. STREET ADDRESS 5808 Westwood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernestine Middle W. Last Herauf (Reinhardt)		4. DATE OF DEATH Month October Day 8 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Stettin-Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franz Loessin		14. MOTHER'S MAIDEN NAME Ernestine Zastrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Owen E. Termollan Jr.		Address 5808 Westwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X. Adenocarcinoma Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9-25-61 7			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 25, 1961 to Oct 8, 1961 , that I last saw the deceased alive on Oct 8, 1961 and that death occurred at 6 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED Oct 10 1961			
ACTUAL SIGNATURE Michael J. Grossfeld M.D.		DATE SIGNED Oct 10 1961	
PHYSICIAN'S NAME (Type) Michael J. Grossfeld			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-11-61	22c. NAME OF CEMETERY OR CREMATORY Jerusalem Luth. Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR Oct 10 1961	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 11/59

11108

11099

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b 3 years 9 mo d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE City d. STREET ADDRESS 740 N PAYSON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle ELSWORTH Last HILTNER		4. DATE OF DEATH Month OCTOBER Day 31 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.6.1889
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER		10b. KIND OF BUSINESS OR INDUSTRY HOUSE PLASTERING	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY HILTNER		14. MOTHER'S MAIDEN NAME EMMA HISEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-07-2441	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 4 year DUE TO (c) 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) For advanced pulmonary tuberculosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JANUARY 16 1958 to OCTOBER 31 1961 that (I) (we) last saw the deceased alive on OCT 31 1961 and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Newcomer		22b. DATE SIGNED 10/31/61	
22c. PHYSICIAN'S NAME (Type) Dr. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 11-3-61	
23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson		25a. REC'D BY REGISTRAR NOV 3 '61	
25b. REGISTRAR'S SIGNATURE Carlton S. Kruess			

BURIA

50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

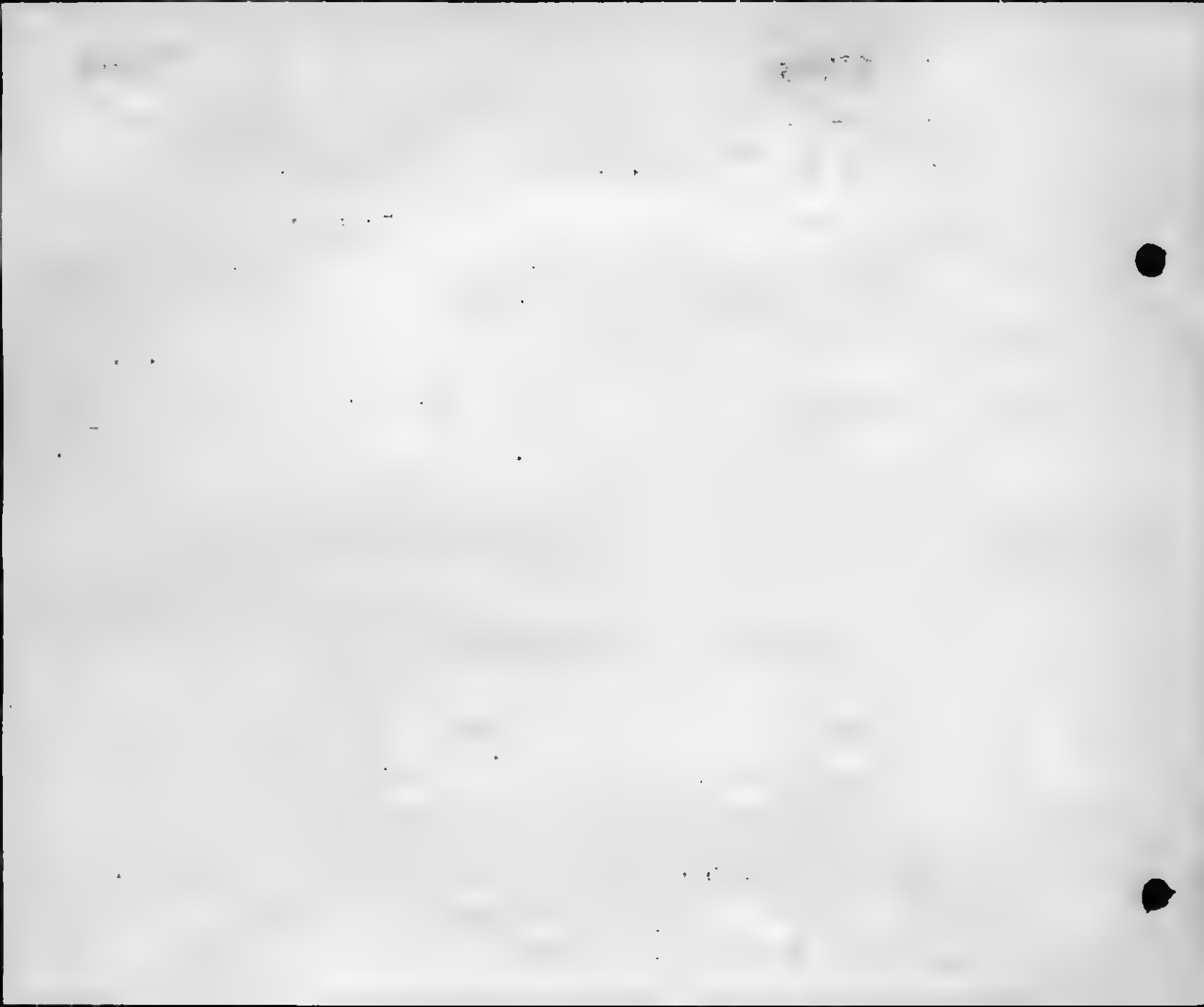
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11109

11100

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> 28, <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3857 Forest Park Ave.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>Baltimore - 16, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Rose</u> First Middle Last		4. DATE OF DEATH <u>October 1 1961</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>sister:</u>		Address <u>Baltimore - 7</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease, in failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis, severe</u> (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Under nourishment</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 24, 1960</u> to <u>October 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 1, 1961</u> , and that death occurred at <u>5:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>S. Mrs. Kopits</u> M.D.		22b. DATE SIGNED <u>10/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Imre KOPITS, M.D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Baltimore - 28 (Catonsville), Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-4-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young men</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles S. Knaus</u>	
25c. ADDRESS <u>2100 Eutaw Place</u>		DATE <u>OCT 5 '61</u>	

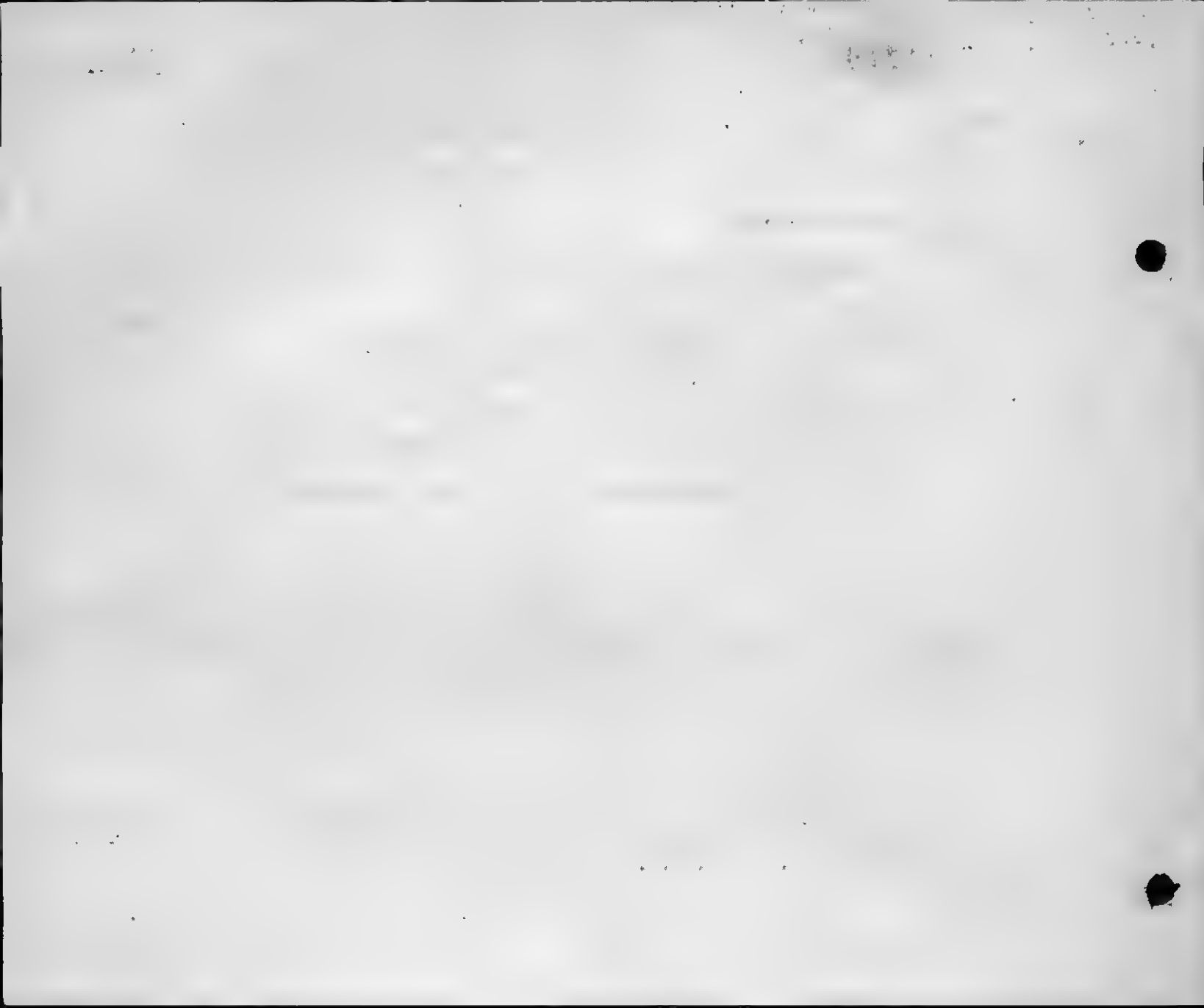


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISM
SM 9/60

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
11110 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 111101											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland				b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 60				c. LENGTH OF STAY IN 1b 10 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 63			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 290 Ridge Road, Balto. 6				d. STREET ADDRESS 290 Ridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREDERICK				4. DATE OF DEATH 10 14 1961				5. SEX Male			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 1-18-1891			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Carpenter				9. AGE (In years last birthday) 70			
11. BIRTHPLACE (State or foreign country) North Dakota				12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME John Hoffman			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-07-5187			
17. INFORMANT Mrs Lottie Hoffman				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				Interval Between Onset and Death			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-14-61											
ACTUAL SIGNATURE Howard G. Shaub				EXAMINER'S NAME (Type) Howard G. Shaub, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 10-17-1961				22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.				22d. LOCATION (City, town, or country) (State) Baltimore Md.			
23. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				24a. REC'D BY REGISTRAR OCT 17 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

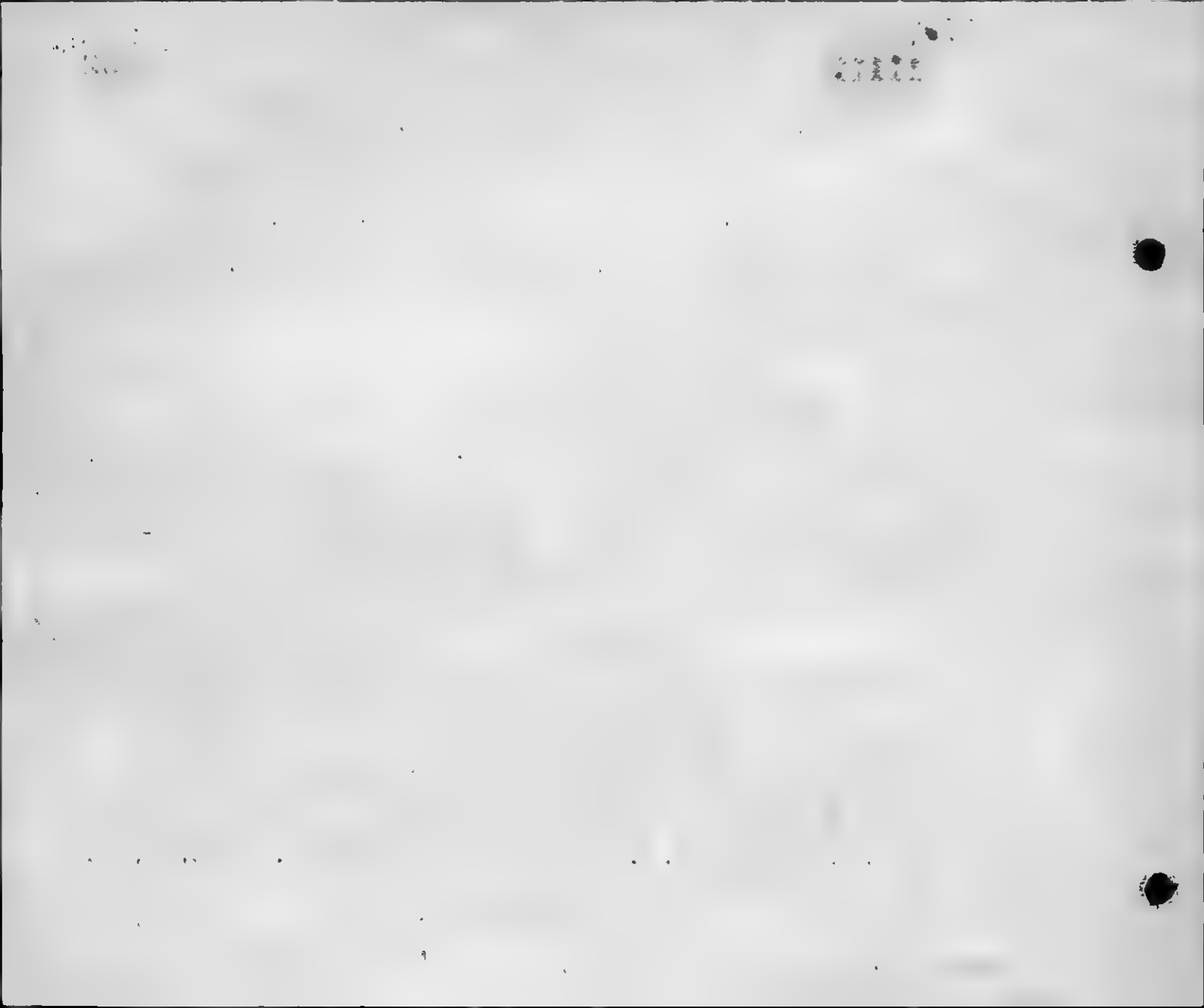
CERTIFICATE OF DEATH

11111

11102

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1810 Berrywood Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>alt.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>8813 Victory Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Dorothy C. Hoopes</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1961</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-9-1909</u>					
9. AGE (In years last birthday) <u>51</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours M'n.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours M'n.	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours M'n.						
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles Seigert</u>		14. MOTHER'S MAIDEN NAME <u>Chilemena Simpson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war and dates of service)</u>		16. SOCIAL SECURITY NO. <u>213424042</u>					
17. INFORMANT <u>John A. Hoopes 1810 Berrywood Rd.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Internal hemorrhage</u> <u>155.1</u> DUE TO <u>Carcinoma of Gall Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>with extensive metastasis</u> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 29, 1961</u> to <u>Oct 1, 1961</u> that (I) (we) last saw the deceased alive on <u>Sept 29, 1961</u> and that death occurred at <u>5:24 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. F. Palmisano</u>		22b. DATE SIGNED <u>10/2/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>J. F. Palmisano, M. D.</u>		22d. ADDRESS <u>6608 Loch Raven Blvd. Balto. 12, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-4-61</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Rucc 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>Oct 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11112

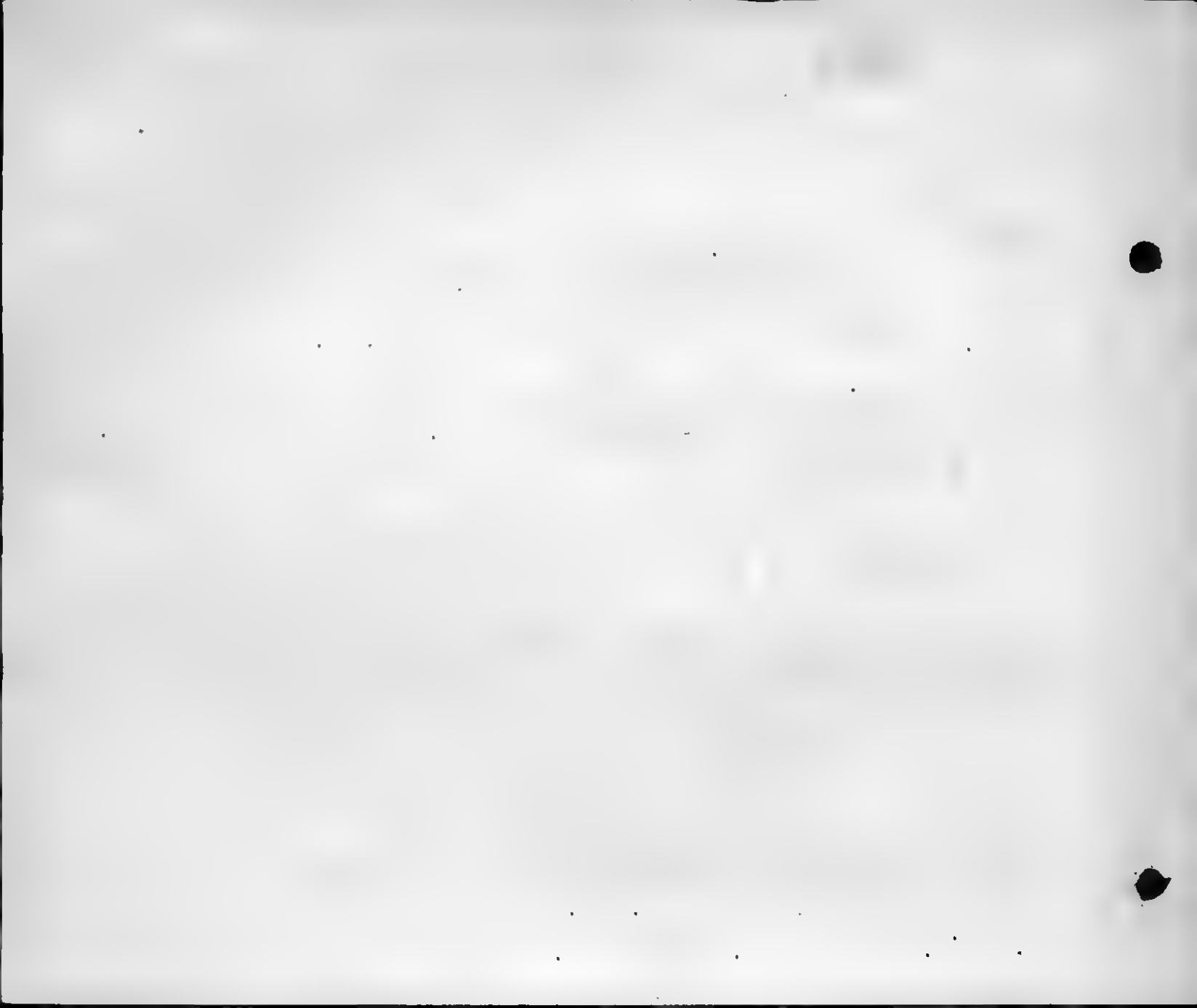
CERTIFICATE OF DEATH

Reg. Dist. No. 11103

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8434 Greenway Road</u>		d. STREET ADDRESS <u>8434 Greenway Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Edmund C.</u> Middle <u>Horton</u> Last <u></u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Confect Bus</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Confect Bus</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Horton</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ellinghaus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>218-32-0556</u>	
17. INFORMANT <u>Mrs Mary E. Horton</u> Address <u>8434 Greenway Rd.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1.5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 4</u> , 19 <u>61</u> , to <u>Oct 5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>61</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town) state DATE SIGNED ACTUAL SIGNATURE <u>Frederick J. Moran</u> M.D. <u>Frederick J. Moran</u> PHYSICIAN'S NAME (Type) <u>Frederick J. Moran</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 9, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore St.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Hanks</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

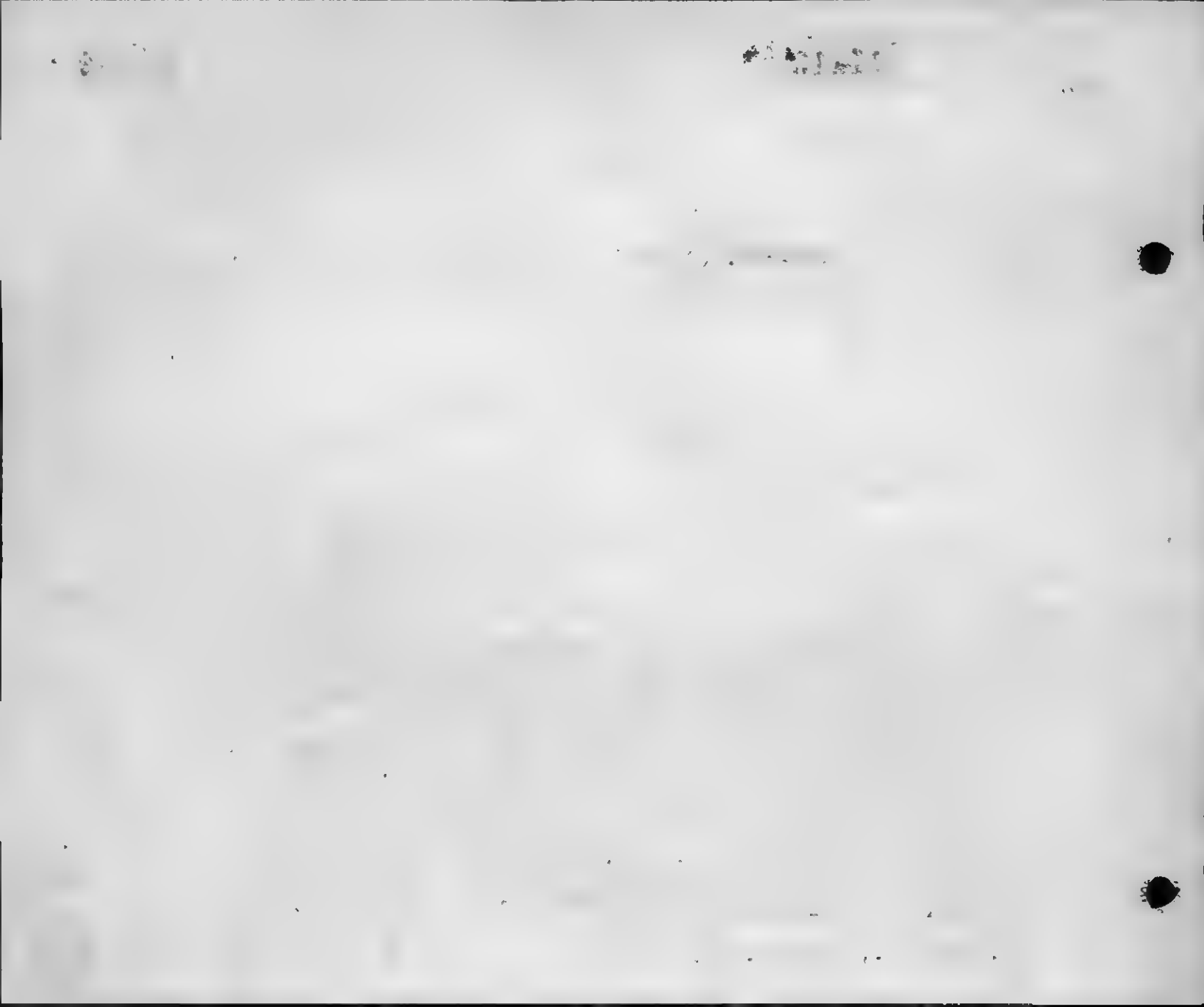
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11113
11104
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 yr 10 mth 16 dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 235 Bloomsbury Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah E. (Bessie) Hullett		4. DATE OF DEATH Month Oct.		Day 24	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 26, 1879		9. AGE (In years, last birthday) 82 yrs.		IF UNDER 1 YEAR Months 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cerebrovascular accident arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 1, 1959 to Oct. 24, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 24, 1961 , and that death occurred at 4:15 a.m. from the causes and on the date stated above.		22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED Oct. 27 '61	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		22d. ADDRESS SPRING GROVE STATE HOSP. Catonsville 28, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-27-61		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery	
23d. LOCATION (City, town or county) Baltimore		23e. (State) Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street	
24. ADDRESS Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE OCT 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



11114

CERTIFICATE OF DEATH

Reg. Dist. No.

11105

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Maria - Notch Cliff		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sister M. Sylvana Middle (Hunn) Last		4. DATE OF DEATH Month 10 Day 22 Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 - 31 - 1870
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	11. BIRTHPLACE (State or foreign country) Switzerland
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Xavier Hunn	
14. MOTHER'S MAIDEN NAME Genevieve Ast		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Sr.M. Henrica Villa Maria, Glenarm, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan. 19 45 , to Oct. 19 61 , that I last saw the deceased alive on Oct. 19 61 , and that death occurred at 6:15 p.m. from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-24-61	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCHCLIFF NR TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. O'Donnell		24a. REC'D BY REGISTRAR OCT 26 '61	
24b. REGISTRAR'S SIGNATURE Charles F. O'Donnell		24c. ADDRESS 901 S. CONKLING ST. BALTO, MD.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1944



FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

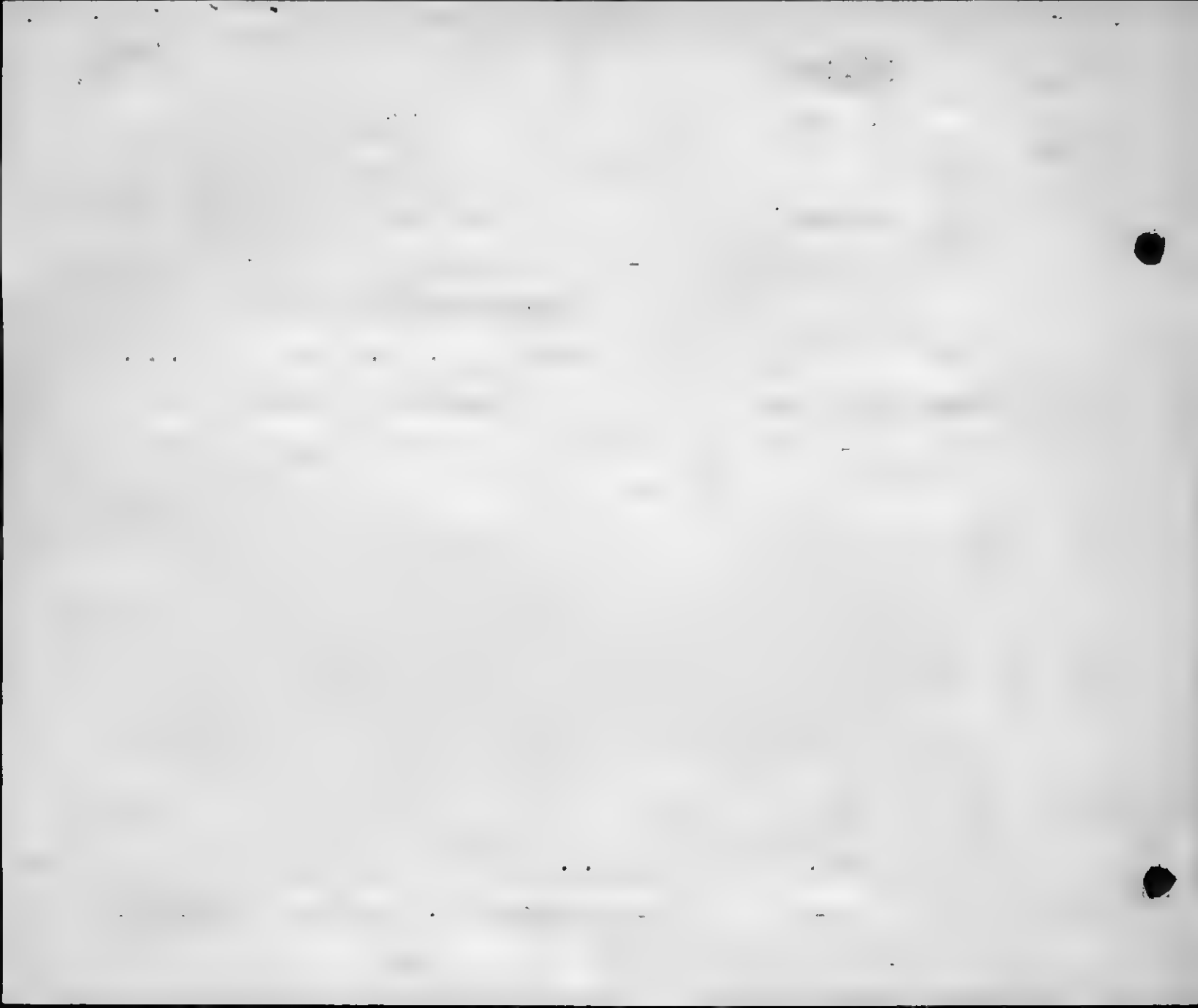
VS. A15ME
SM 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fort Howard		c. LENGTH OF STAY IN 1b		1 Hour		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Veterans Administration Hospital		Baltimore		2924 Riggs Avenue		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		Fred		Middle		4. DATE OF DEATH		October 19 19 61	
5. SEX		Male		6. COLOR OR RACE		Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH		April 7, 1895		9. AGE (In years last birthday)		66 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Laborer - Retired		10b. KIND OF BUSINESS OR INDUSTRY		Chemical Company York Co., So. Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Unknown Major Jackson		14. MOTHER'S MAIDEN NAME		Unknown Jennie Williams		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		Yes WW-1		16. SOCIAL SECURITY NO.		246-22-3073		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Septicemia		Pen rectal Abscess		Clin Rec VAH Baltimore Md - Ft Howard Division		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		5-1 X		DUE TO		(b)		4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Jack C. Collins		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Jack C. Collins		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10-19-61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		10-22-61		22c. NAME OF CEMETERY OR CREMATORY	
23. FUNERAL DIRECTOR		Charles G. Cooper		512 Carrollton Avenue		Baltimore Maryland		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		C. J. L. Thomas		DATE		OCT 24 '61			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

O

1

107

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11117 CERTIFICATE OF DEATH 11108											
1. PLACE OF DEATH a. COUNTY <u>MALTE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHADY NOOK HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4001 FREDERICK AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CLARA L. JARBOE</u>				4. DATE OF DEATH <u>10-21 1961</u>				9. AGE (In years last birthday) <u>81</u> yrs.			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 15, 1880</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE-PRCS.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MOVING BUS</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MICHAEL KAISER</u>				14. MOTHER'S MAIDEN NAME <u>MARY VAETH</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>George H. Jarboe Jr - 4001 Frederick Ave</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443 X</u> DUE TO (b) <u>Hypertensive Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Disease with many Cerebral Thrombi</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 years</u>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> 19 <u>34</u> to <u>10/21</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/21</u> 19 <u>61</u> and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Elmer W. Jarboe</u>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <u>Elmer W. Jarboe</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>10-25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore 29. Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Cunningham</u>				ADDRESS <u>1414 E. Lombard St. Baltimore, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

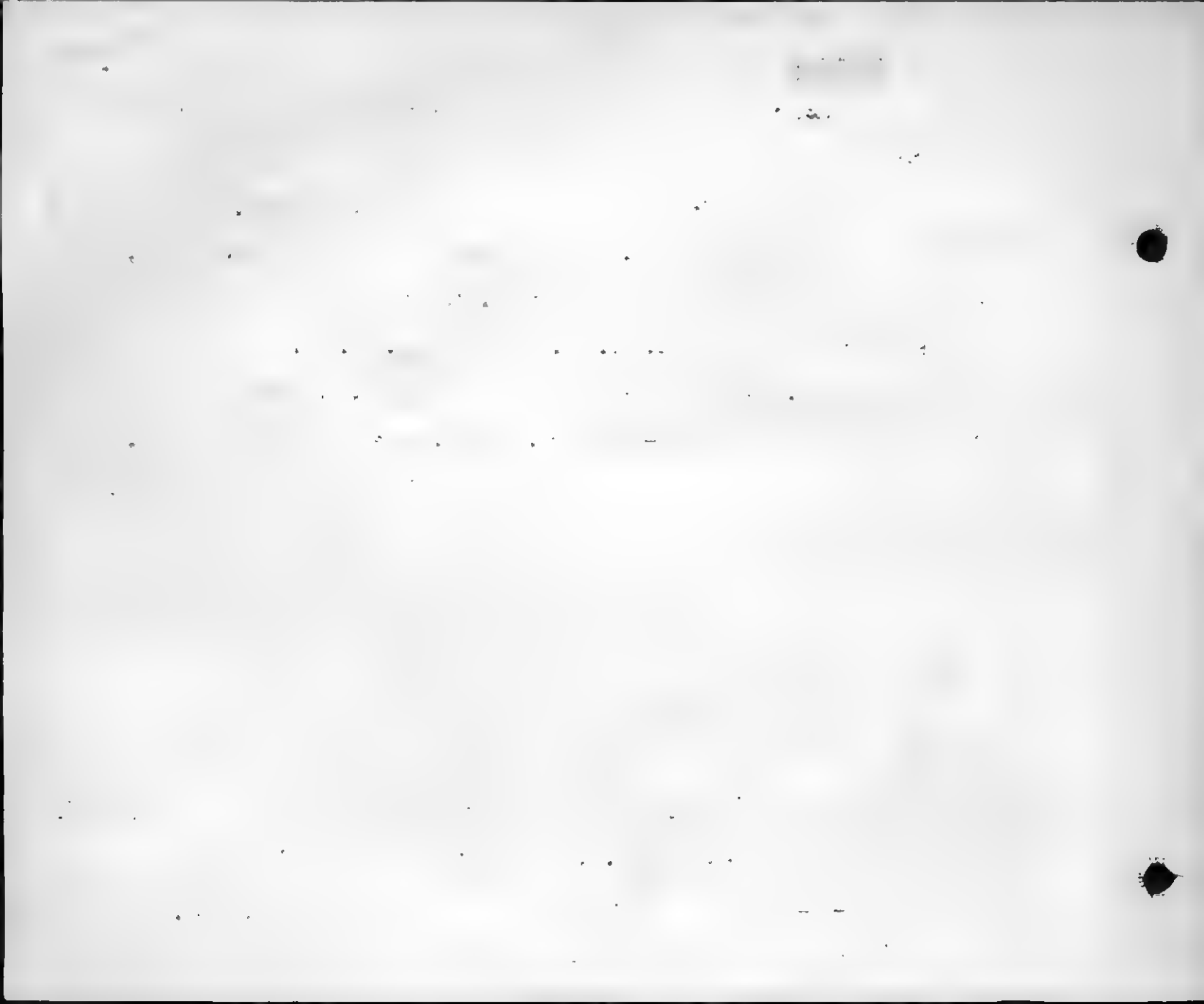
11109

11118

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4233 Cardwell Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carl Middle H. Last Jones		4. DATE OF DEATH Month October Day 20 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1891
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tax Assessor		10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Md.	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. Jones		14. MOTHER'S MAIDEN NAME Bertha E. Bishop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-20-4210	
17. INFORMANT Mrs. Edna E. Jones		Address 4233 Cardwell Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular many years 422.1 DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized Arteriosclerosis DUE TO (c) 11			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-31 , 19 58 , to 10-20 , 19 61 ; that I last saw the deceased alive on 10-19 , 19 61 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5713 Belair Road DATE SIGNED 10/21/61 ACTUAL SIGNATURE Max R. English M.D. PHYSICIAN'S NAME (Type) Max R. English, M.D. Baltimore-6, Maryland			
22a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial	22b. DATE THEREOF 10-23-1961	22c. NAME OF CEMETERY OR CREMATORY Baltimore	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home		24a. REC'D BY REGISTRAR DATE OCT 23 '61	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

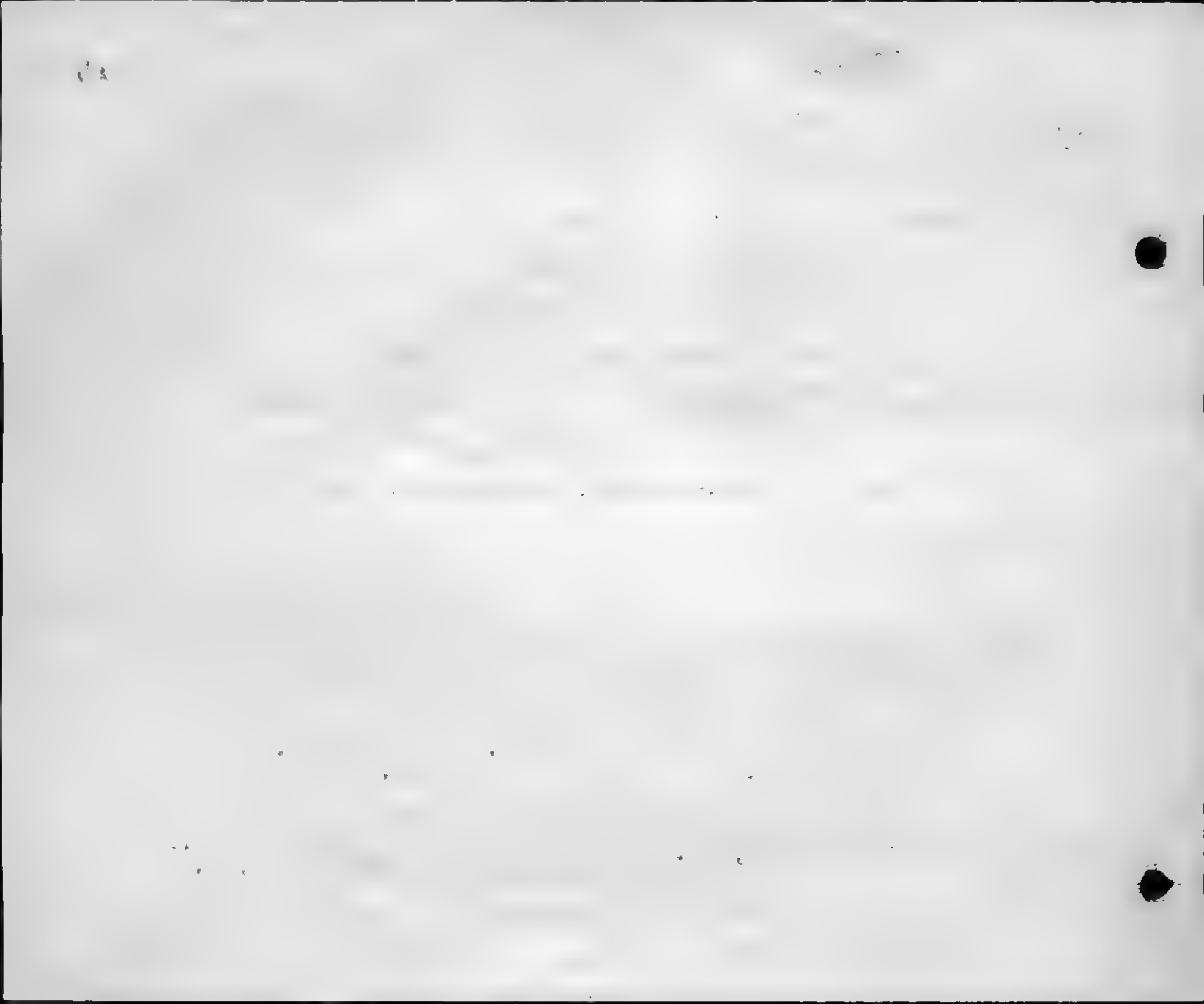
11119

CERTIFICATE OF DEATH

11110

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shady Nook Conv. Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> d. STREET ADDRESS <u>2001 N. Rolling Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>JENNIE LEE KALB</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>3/31/76</u>		9. AGE (In years last birthday) <u>85</u> yrs. <table border="1" style="display: inline-table; font-size: 0.8em;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months Days	Hours Min.								
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James P. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Martin Horn</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edgar A. Kalt</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (e), stating the underlying cause last. _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Hour _____ e.m. _____ p.m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____					
20f. (City or town) _____		20g. (County) _____		20h. (State) _____					
21. I certify that (1) (the deceased) attended the deceased from <u>Sept. 1951</u> to <u>Oct. 1961</u> that (1) (we) last saw the deceased alive on <u>Oct. 26</u> 19 <u>61</u> , and that death occurred at <u>1A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Leo J. Gaver</u>		22b. DATE SIGNED <u>10/29/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>					
22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md.</u>		23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>Oct. 31/1961</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>Torrance</u>		23d. LOCATION (City, town or county) <u>Balt. Co. Md.</u> (State) _____							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don</u>		25a. REC'D BY REGISTRAR <u>NOV 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and within 24 hours after death, page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11120

CERTIFICATE OF DEATH

11111

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>Byeans 9 Mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2-1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> d. STREET ADDRESS <u>1 707 Regester Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Anna</u> First Middle Last <u>Female</u> Sex <u>White</u> Color or Race <u>82</u> Age (in years, last birthday) <u>October 24, 1961</u> Date of Death <u>December 2, 1878</u> Date of Birth <u>82</u> Age (in years, last birthday)	4. DATE OF DEATH Month Day Year <u>October 24, 1961</u>	5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 2, 1878</u>	9. AGE (in years, last birthday) <u>82</u> yrs. Months Days Hours M'n.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Sales</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Gerrit Kamps</u>		14. MOTHER'S MAIDEN NAME <u>Elise Soth</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>F. Kamps, 707 Regester Ave., Balto., Md.</u>		17. INFORMANT <u>F. Kamps, 707 Regester Ave., Balto., Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1960</u> to <u>Oct 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 24, 1961</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Laurence C. Post</u>		22b. DATE SIGNED <u>10/24/61</u>		22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		22d. ADDRESS <u>6805 York Rd Baltimore Md</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/26/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Co., Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Frank</u>	

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4

VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

11121

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11112

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3468 Dunran Rd.</u>				d. STREET ADDRESS <u>3468 Dunran Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Y.</u> Last <u>Kapcsos</u>				4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1921</u>	
9. AGE (In years last birthday) <u>40</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Flair</u>				14. MOTHER'S MAIDEN NAME <u>Orpha Buttermann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>John P. Kapcsos, 3468 Dunran Rd., Balto 22, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 year</u>						19. WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 27, 1961</u> to <u>Oct 1</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Oct 10</u> , 19 <u>61</u> and that death occurred at <u>M</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Antonio A. de la Fuente</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>October 4, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIA A. de la FUENTE</u>				22d. ADDRESS <u>Maryland General Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, or county) (State) <u>Catonsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home, Dundalk, Maryland</u>				ADDRESS <u>Ullrich Funeral Home, Dundalk, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 6 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

Chronic Myelogenous Leukemia

• 1974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11122

CERTIFICATE OF DEATH

11113

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN It <u>122 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5601 Plymouth Road</u>	
3. NAME OF DECEASED (Type or print) <u>Milton</u> First Middle Last 4. DATE OF DEATH <u>October 1 19 61</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 1 1914</u> 9. AGE (In years last birthday) <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receiving Clerk</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Leather Goods Store Baltimore Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lawrence Kasiura</u> 14. MOTHER'S MAIDEN NAME <u>Mary Borsukiewicz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-11</u> 16. SOCIAL SECURITY NO. <u>WW-11</u> 17. INFORMANT <u>Clin Rec VAH Baltimore Md Ft Howard Division</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLOMERULONEPHRITIS, CHRONIC</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus; Hypertensive Cardiovascular Disease; Thrombosis of right middle Cerebral Artery; Infected Decubiti</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 1 1961</u> to <u>Oct 1 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct 1 1961</u> , and that death occurred at <u>5:00 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. M. Snyder</u> 22c. PHYSICIAN'S NAME (Type) <u>C. M. Snyder</u> M.D.		22b. DATE SIGNED <u>10-1-61</u> 22d. ADDRESS <u>VAH Balto Md - Ft Howard Division</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct 5-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W Ozazewski</u> ADDRESS <u>1930 Eastern Ave Baltimore 34 Md</u> 25a. REC'D BY REGISTRAR <u>DATE OCT 4 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

Table 4 (continued)

1

5

20

1

14
M
I
TO ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11123

CERTIFICATE OF DEATH

11114

Item 9 Film G297 10/11/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>College Manor</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1308 Argonne</u>	
3. NAME OF DECEASED (Type or print) <u>Maggie E. Keese</u> 4. DATE OF DEATH <u>10 5 1961</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. AGE (In years last birthday) <u>10-29-1874</u> 9. AGE (In years last birthday) <u>1874</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Oscar Marks</u> 14. MOTHER'S MAIDEN NAME <u>Harriet Hansen</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>1140 Keller K.H.</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uterine cancer</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		21. I certify that (I) (this hospital) attended the deceased from <u>9-21-61</u> 19 <u>61</u> , to <u>Oct 5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 5</u> 19 <u>61</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above. 22a. SIGNATURE <u>Ernest C. Brown Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u> 22d. ADDRESS <u>1101 N. Calvert St. Bal. 2 Md.</u> 22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 10/9/61</u> 23b. DATE THEREOF <u>10/9/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u> 23d. LOCATION (City, town or county) <u>BALTIMORE</u> (State) <u>MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>L.J. Ruck</u> ADDRESS <u>5305 HARFORD RD.</u> 25a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 9 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



within 24 hours after

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined by the attending physician and completely filled in by the funeral director, page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
M 9/60

M

I

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 3yr7mth9dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp'tal, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air, Maryland d. STREET ADDRESS 625 Roland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Julia Marie Kelly		4. DATE OF DEATH OCT. 14 1961		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1906	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher 10b. KIND OF BUSINESS OR INDUSTRY Public Schools				9. AGE (In years last birthday) 55 yrs. 11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Kelly				14. MOTHER'S MAIDEN NAME Julia Lerner				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 220-24-2883 17. INFORMANT (Sister) Mrs. Helen Kelly Address 625 Roland Ave., Bel Air, Md. Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) (a), stating the underlying cause last. DOX PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that he (this hospital) attended the deceased from March 4, 1958 , to 10/14, 1961 , that (I) (we) last saw the deceased alive on Oct. 14, 1961 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. 22a. SIGNATURE Jose R. Arizaga M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Oct. 16, 1961 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens 23d. LOCATION (City, town or county) (State) Bel Air, Harford Co., Maryland				24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. Bel Air, Maryland 25a. REC'D BY REGISTRAR DATE OCT 16 1961 25b. REGISTRAR'S SIGNATURE							



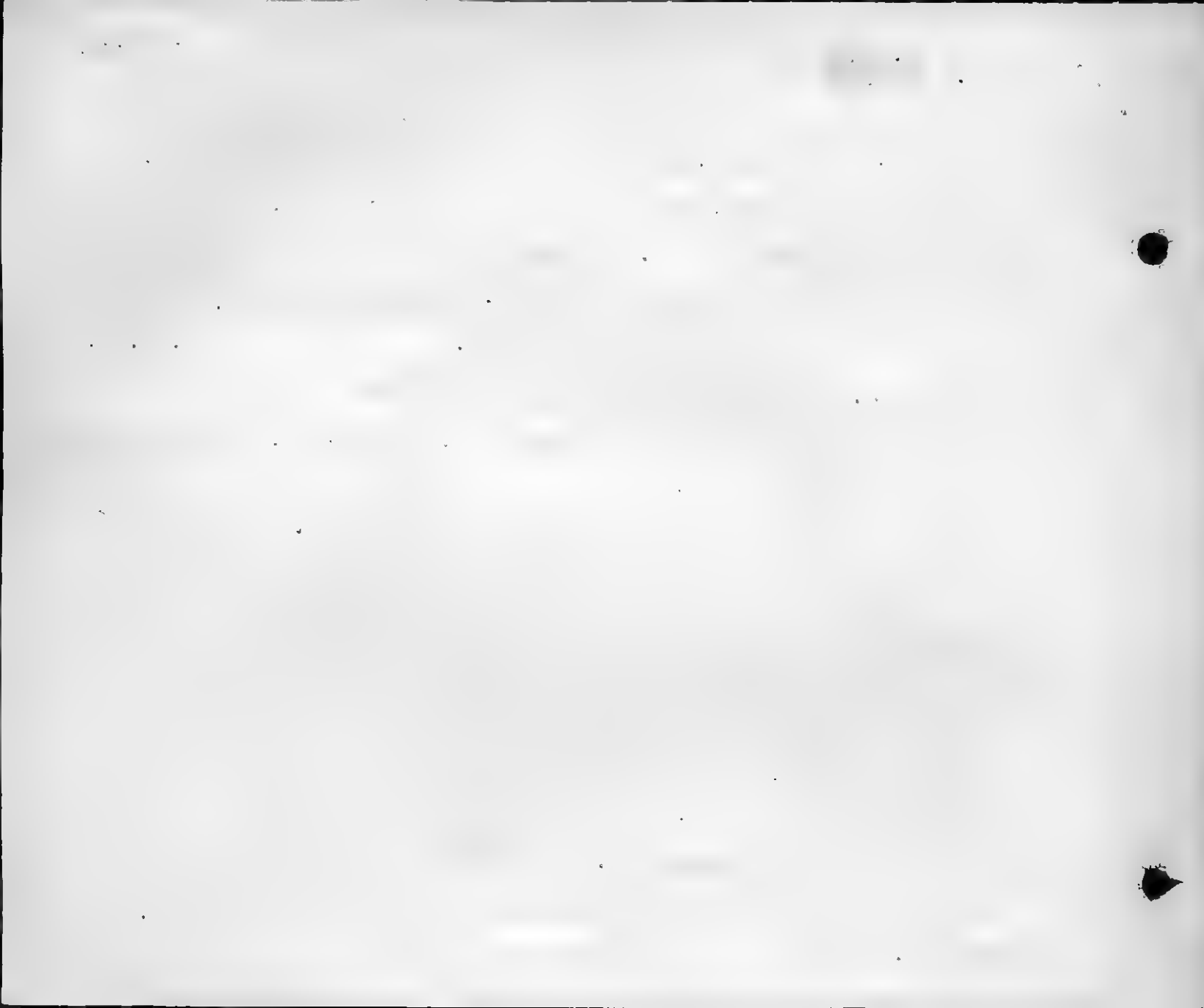
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11116

11125

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Relay, Md.)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Relay, Md.)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1719 Sutton Avenue				e. STREET ADDRESS 1719 Sutton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellen Middle R. Last Kennedy				4. DATE OF DEATH Month Oct. Day 3, Year 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1866		9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Peter J. Brookey				14. MOTHER'S MAIDEN NAME Ellen Ford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Albert A. Kennedy, Sr. 1804 Woodside Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 420-1 DUE TO (b) Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1955 to Oct 3, 1961 , that (I) (we) last saw the deceased alive on Sept 21, 1961 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE John F. Coolahan		M. D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/4/61	
22c. PHYSICIAN'S NAME (Type) John Coolahan, M.D.		22d. ADDRESS 4201 Wilkens Avenue #29					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/7/61	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR DATE OCT 5 '61		25b. REGISTRAR'S SIGNATURE William L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

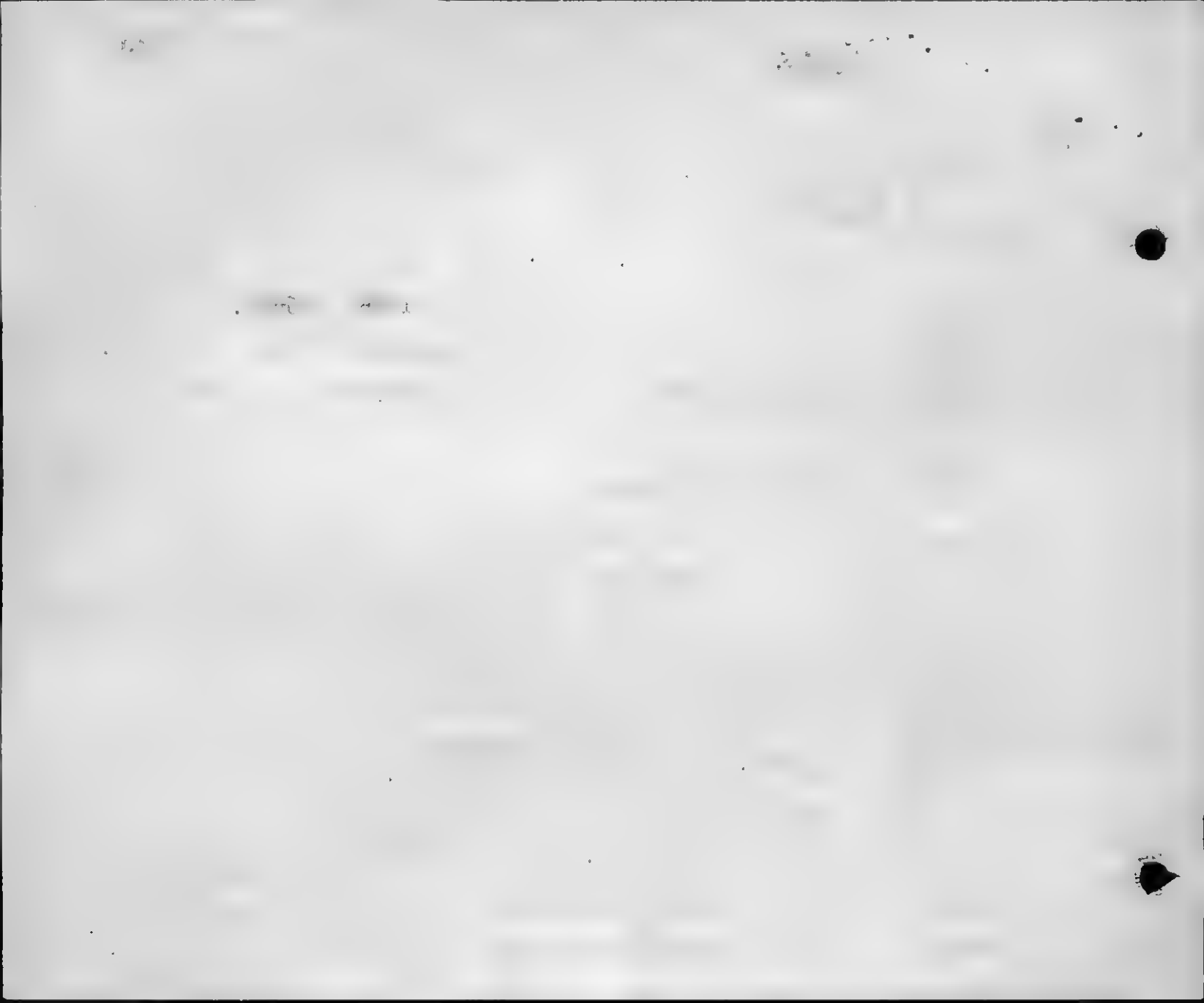
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.
11126 **CERTIFICATE OF DEATH** **1111**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1mth 17dys</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>							
3. NAME OF DECEASED (Type or print) <u>Susan B. Kennedy</u>				4. DATE OF DEATH Last <u>Month</u> <u>Day</u> <u>Year</u> <u>October 2 19 61</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1885</u>	
9. AGE (In years last birthday) <u>76yrs.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX</u>		11. BIRTHPLACE (County & State, or foreign country) <u>XXXXXX Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>XXXXXX Milton Orndorff</u>			
14. MOTHER'S MAIDEN NAME <u>XXXXXX Kissiah Linderman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural Effusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>Arteriosclerotic heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <u>Aug. 15 1961</u> to <u>Oct. 2 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 2 1961</u> , and that death occurred at <u>10:20</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachler, M. D.</u>				22b. DATE SIGNED <u>10-2-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/ 5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				25a. REC'D BY REGISTRAR <u>OCT 5 '61</u>			
ADDRESS <u>4107 Wilkens Avenue</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11127

11118

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 241 RIDGEWAY RD				d. STREET ADDRESS 1241 RIDGEWAY RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT R. KIRBY				4. DATE OF DEATH OCT. 10, 1961		9. AGE (In years last birthday) 68 yrs.	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 26, 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER-RET. SELF-EMP.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME HOWARD KIRBY				14. MOTHER'S MAIDEN NAME ELLA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If given, give word or dates of service)		17. INFORMANT Mrs. Robert R. Kirby-241 Ridgeway Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of Bile Ducts (c) 2 yrs. DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 10, 1961 to Oct. 10, 1961 , that (I) (we) last saw the deceased alive on Oct. 10, 1961 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE J. Nelson McKay M.D.				22b. DATE 10/11/61		22c. ADDRESS 6014 EDMONDSON AVE	
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
J. Nelson McKay		Burial		10-13-61		Cathedral Em.	
24. FUNERAL DIRECTOR'S SIGNATURE July - Cunningham - Catonsville Md		24b. ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

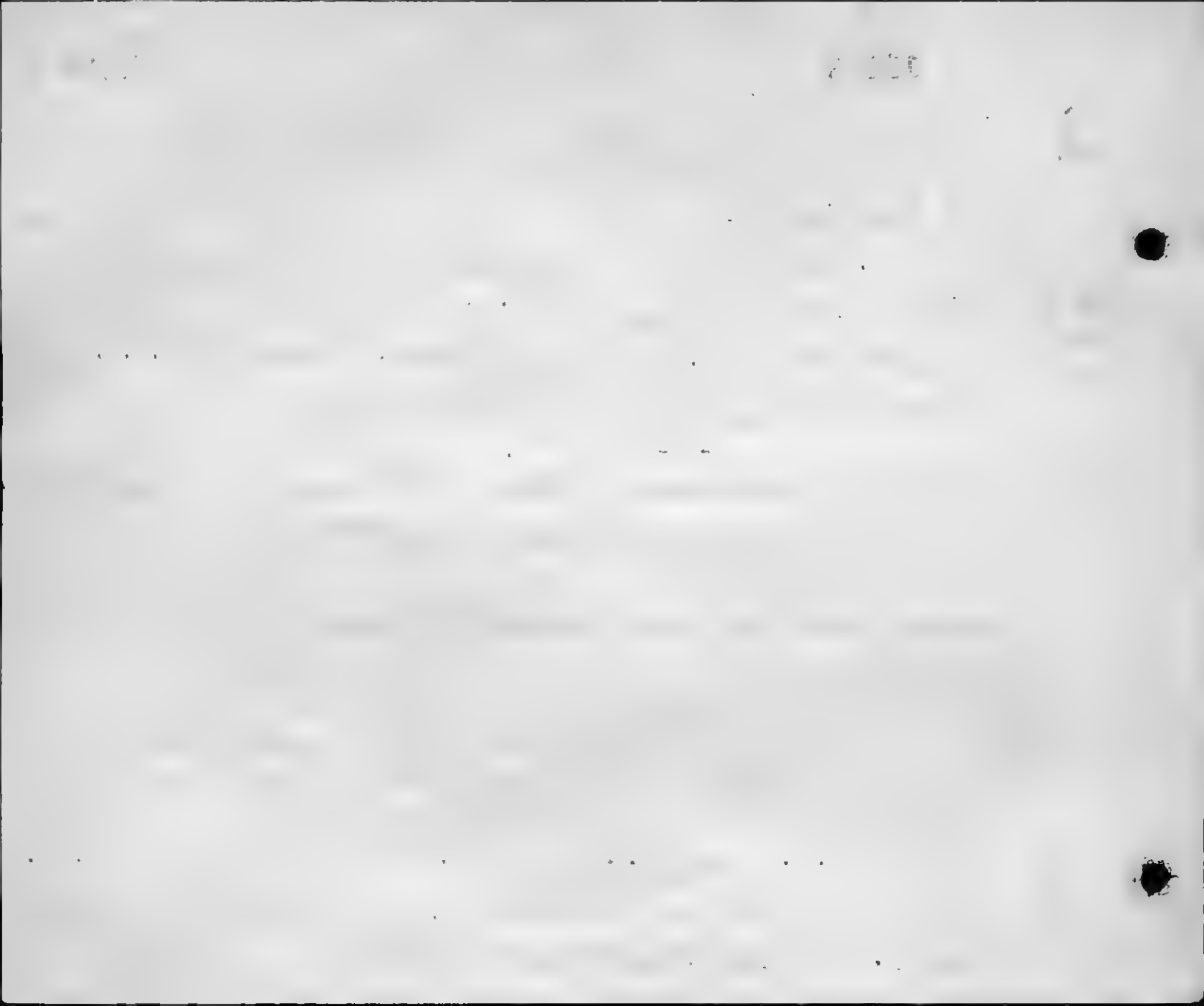
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11128

CERTIFICATE OF DEATH

11119

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>209 Ridgely Road</u>		d. STREET ADDRESS <u>209 Ridgely Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. John Charles Kirchner</u>		4. DATE OF DEATH <u>October 27th 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1899</u>
9. AGE (in years last birthday) <u>62</u>		10. IF UNDER 1 YEAR: Months <u>62</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed Adt.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Kirchner</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Schaefer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>4201</u>		16. SOCIAL SECURITY NO. <u>242-07-7547</u>	
17. INFORMANT <u>Mrs. Sophia Kirchner</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY ARTERY OCCLUSION</u> (b) <u>CORONARY ARTERY DISEASE</u> (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>CORONARY ARTERY OCCLUSION MYOCARDIAL INFARCTION 6/1/61</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> to <u>10/27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>T. C. Siwinski</u>		22b. DATE <u>10/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. C. Siwinski, M.D.</u>		22d. ADDRESS <u>206 W. Pennsylvania Avenue, Towson 4, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/30/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Rack</u>		25a. REC'D BY REGISTRAR <u>OCT 30 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>		25c. ADDRESS <u>5305 Harford Road #14</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8 1
M
I
MARYLAND STATE DEPARTMENT OF HEALTH

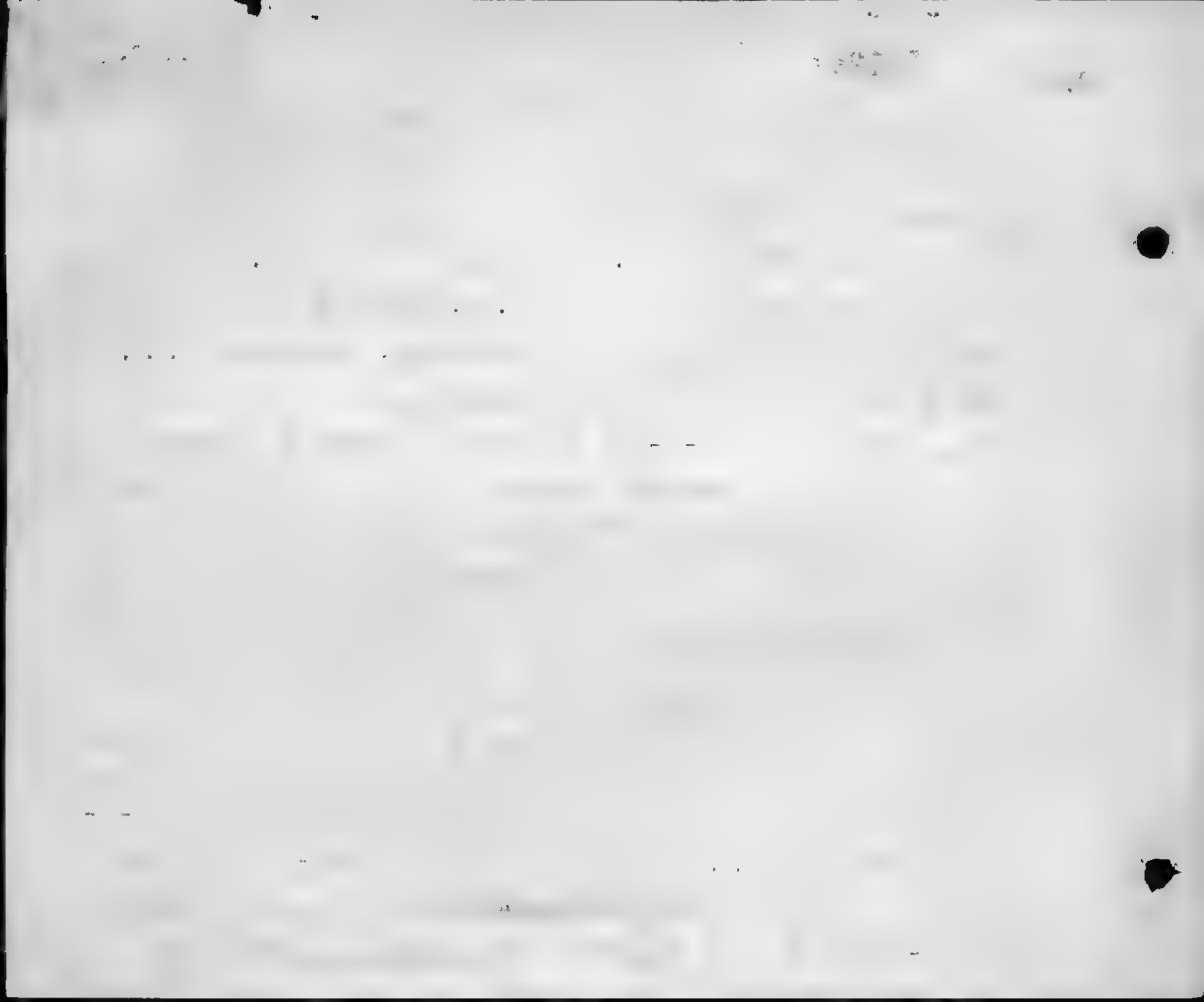
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11129

CERTIFICATE OF DEATH

11120

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>54 Days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3615 Keystone Avenue</u>	
1d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER H. KLOPP</u>		4. DATE OF DEATH <u>Oct. 15 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Berks County, Pennsylvania</u>	
13. FATHER'S NAME <u>Henry Klopp</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>YES</u> <u>SAW</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Burger</u>	
16. SOCIAL SECURITY NO. <u>213-10-1797</u>		17. INFORMANT <u>Clin Rec VAH Baltimore Md Ft Howard Division</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FIBROSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>CHRONIC</u> (b) <u>CORONARY ARTERIOSCLEROSIS</u> (c) <u>LEFT LOWER LOBE PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>2 DAYS +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Nephrosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 22, 1961</u> to <u>Oct. 15, 1961</u> that <u>10</u> (we) last saw the deceased alive on <u>Oct. 15, 1961</u> , and that death occurred at <u>5:25</u> p.m., from the causes and on the date stated above.			
22a. SIGNATURE <u>Sebastian Russo M.D.</u>		22b. DATE SIGNED <u>10-16-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 19, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight Inc</u>		25a. REC'D BY REGISTRAR <u>ACT 17 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11121

11130

1. PLACE OF DEATH a. COUNTY BALTIMORE		(Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY 31	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1148 hrs 8 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 707 N Duncan St. Baltimore	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Anna Middle Korecky Last Korecky			4. DATE OF DEATH Month 10 Day 15 Year 61		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH july 27, 1877		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailor		10b. KIND OF BUSINESS OR INDUSTRY Skrabek's		11. BIRTHPLACE (State or foreign country) Braka, Bohemia	
12. CITIZEN OF WHAT COUNTRY? Bohemia			13. FATHER'S NAME unknown		
14. MOTHER'S MAIDEN NAME unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		
16. SOCIAL SECURITY NO. unknown			17. ADDRESS Records: Spring Grove State Hospital		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration and inanition 4-5-61 DUE TO Due to Gener alized arterteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/61		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS 3331 Brehms Lane		24a. REC'D BY REGISTRAR OCT 17 '61	
24b. REGISTRAR'S SIGNATURE William S. Hanna					

MEDICAL CERTIFICATION

TO COUNTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the County Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

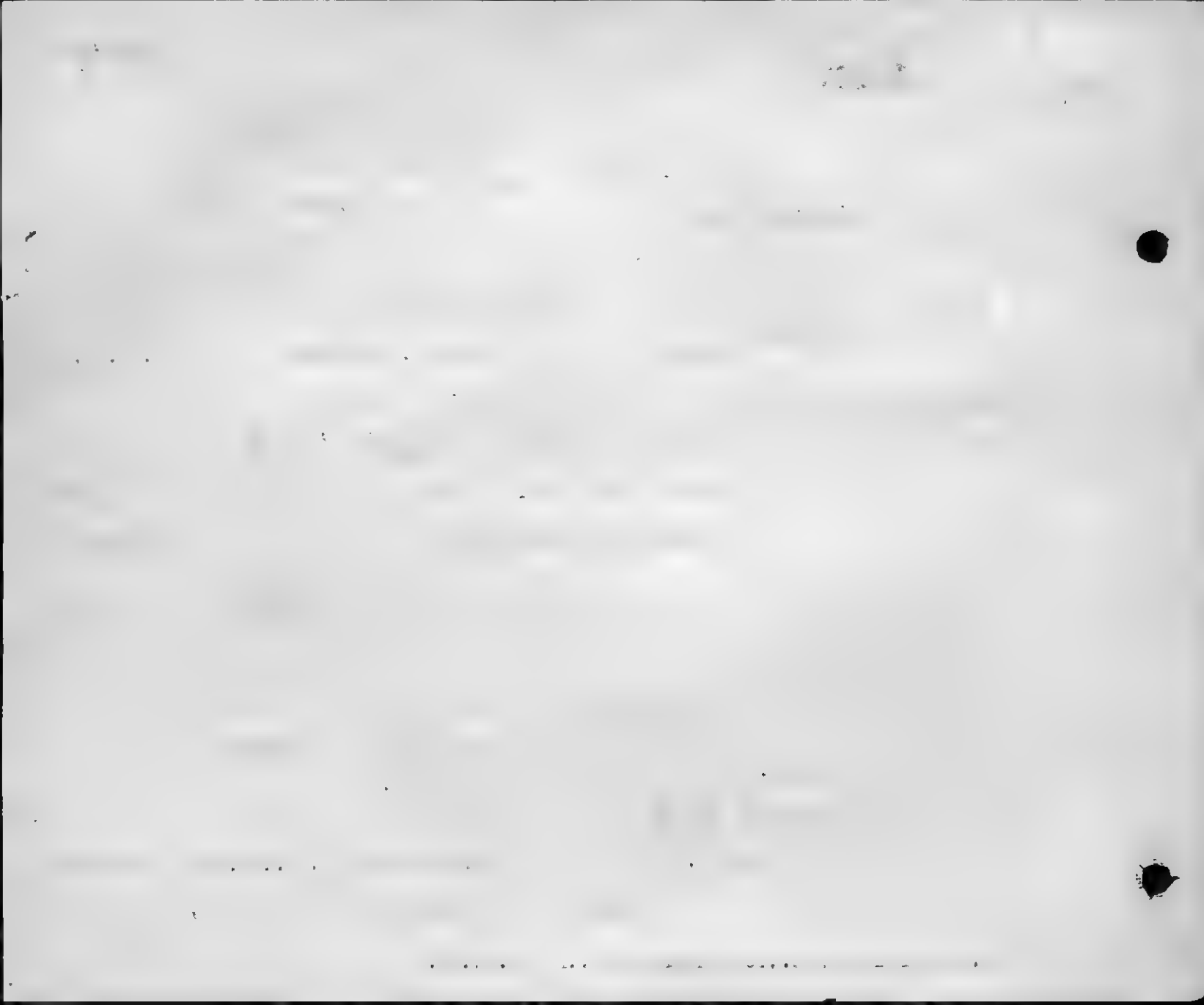
11131

11122

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 11 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 g. STREET ADDRESS 1826 Gough Street h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE First --- Middle KRUG Last		4. DATE OF DEATH Month October Day 3 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1894
9. AGE (In years last birthday) 67 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George Krug		14. MOTHER'S MAIDEN NAME Jennie Darmstead	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 214-05-3813	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF BASILAR ARTERY (b) CEREBRAL ARTERIOSCLEROSIS (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 4:25 e.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from September 22, 1961 to October 3, 1961, that (we) saw the deceased alive on Oct. 3, 1961, and that death occurred at 4:25 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Sebastian Russo		22b. DATE SIGNED 10/4/61	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-6-61	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11132

CERTIFICATE OF DEATH

11123

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>45yr3mth28dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2238 East Baltimore St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bessie Lahey</u>			4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1961</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 19, 1898</u>		9. AGE (In years, last birthday) <u>63 yrs.</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>James Lahey</u>			14. MOTHER'S MAIDEN NAME <u>Mathilda Walters</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, own) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Occlusion of the Coronary Artery (sudden)</u> DUE TO (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis, with Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>none</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 1, 1916</u> to <u>October 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 1, 1961</u> , and that death occurred at <u>9:45 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Imre KOPITS, M.D.</u>				22b. DATE SIGNED <u>9:45 AM</u>			
22c. PHYSICIAN'S NAME (Type) <u>Imre KOPITS, M.D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL, Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery, Essex, Md.</u>			
23d. LOCATION (City, town or county) <u> </u>		23e. (State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Sweeney, Baltimore 18, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>				25c. (State) <u> </u>			

TO SPECIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

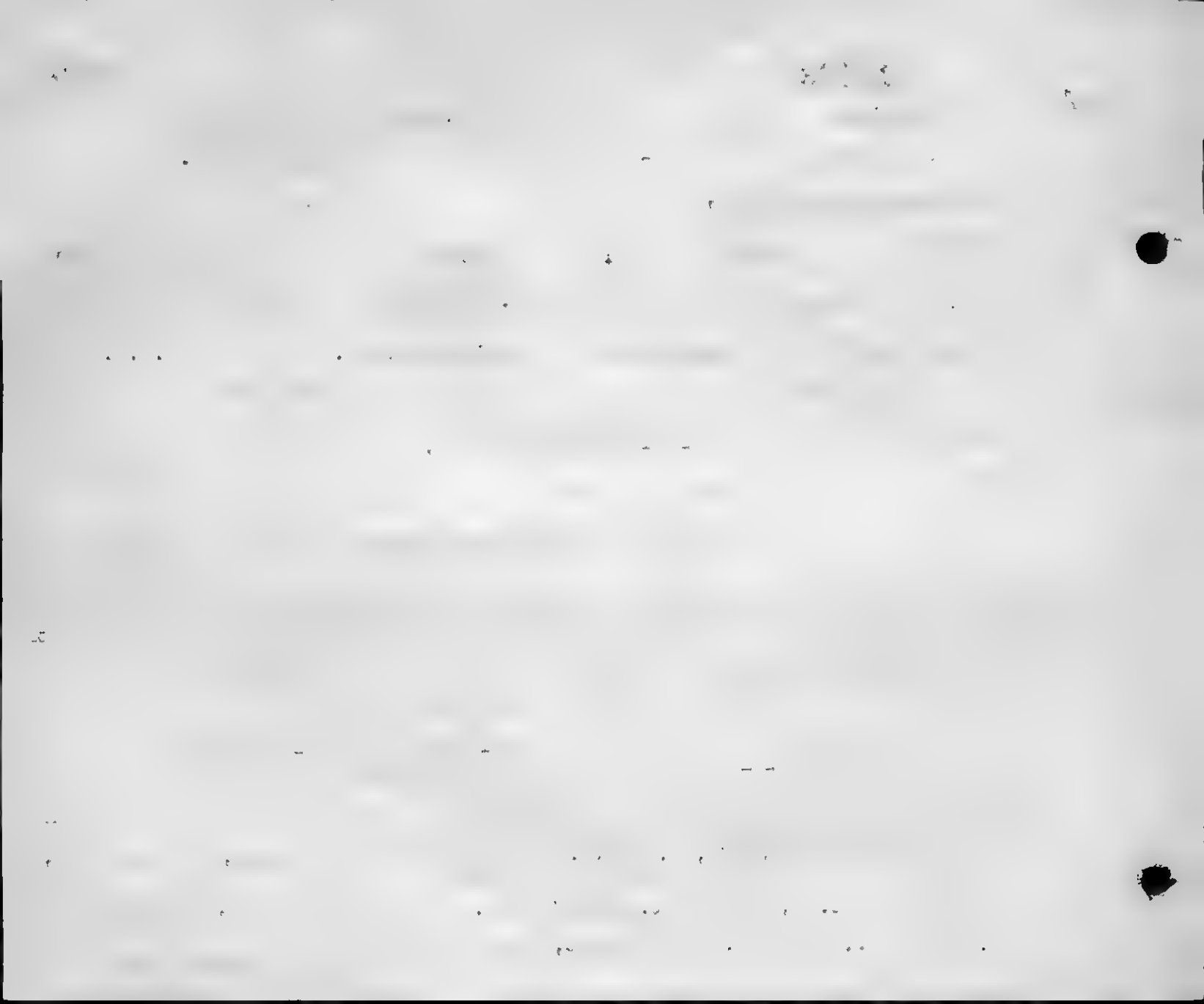
11133

11124

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) e. STATE Maryland b. COUNTY Lansdowne (Baltimore Co.)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b 7-30-1957	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Nursing Home, 329 Harlem Avenue		d. STREET ADDRESS Third Avenue	
3. NAME OF DECEASED (Type or print) George P. Lathe		4. DATE OF DEATH Month October Day 11 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 5 Hours 30 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower		10b. KIND OF BUSINESS OR INDUSTRY Swindell Bros	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gene Lathe		14. MOTHER'S MAIDEN NAME Stella (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 219-07-2305 A	
17. INFORMANT George W. Lathe		Address 5450 Cedonia Avenue	
18. CAUSE OF DEATH (Enter on y one cause per l no for (e), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) Cardiac failure			
DUE TO (b) Arteriosclerotic Cardiovascular Disease			
DUE TO (c) Age			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-30-1957 , 19....., to 10-11-1961 , 19....., that (I) (we) last saw the deceased alive on 10-11-1961 , 19....., and that death occurred 5:30M , from the causes and on the date stated above.			
22a. SIGNATURE Cliff Ratliff, Jr. M.D.		22b. DATE SIGNED 10-11-61	
22c. PHYSICIAN'S NAME (Type) Cliff Ratliff, Jr. M.D.		22d. ADDRESS 4605 Edmondson Avenue, Baltimore 29, Md	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial Oct. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.	
23d. LOCATION (City, town or county) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2	
25a. REC'D BY REGISTRAR DATE OCT 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



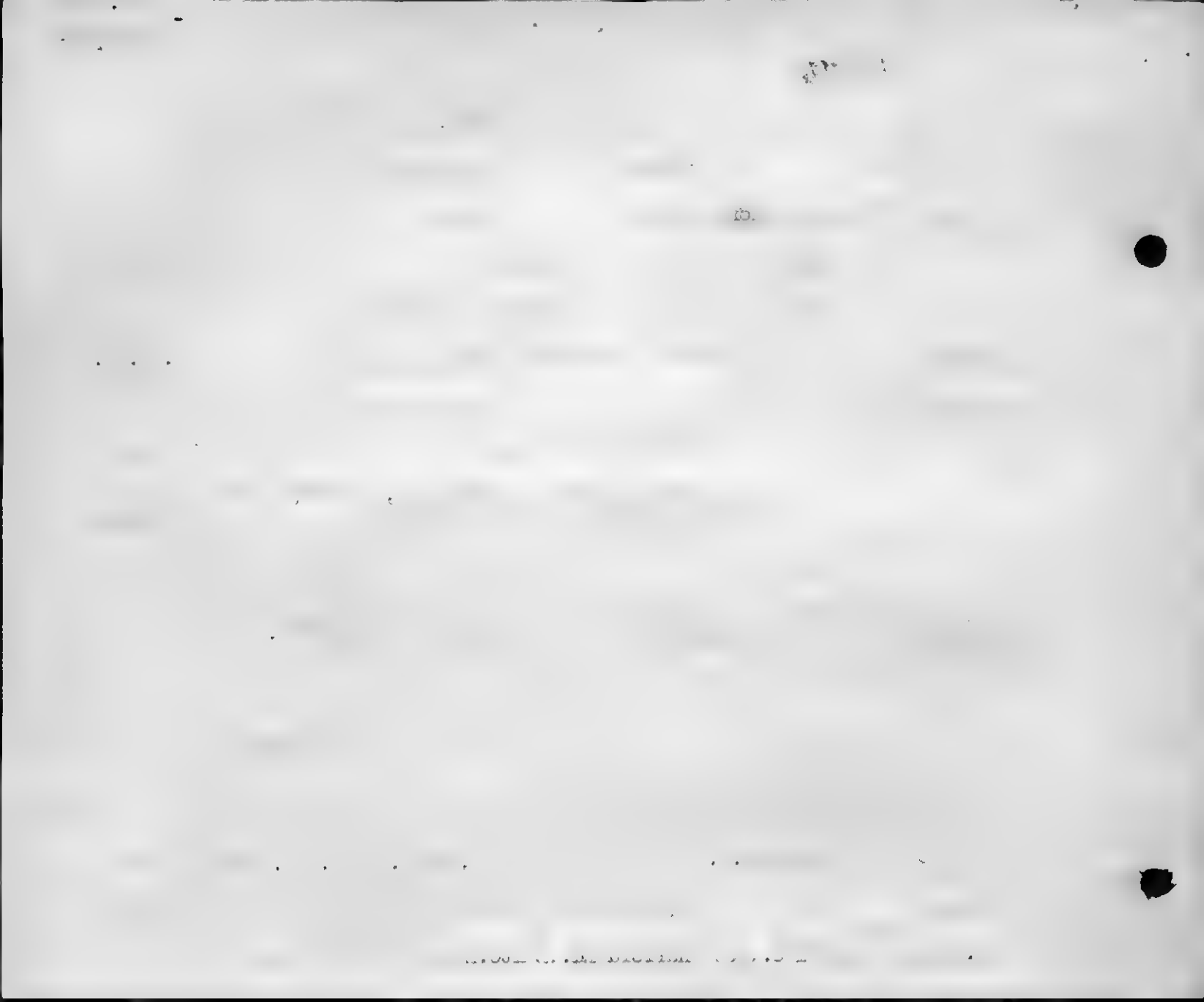
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 11134 11125

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN TB 64 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore 6 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 6 d. STREET ADDRESS Hazelwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First Middle Last LATTIK		4. DATE OF DEATH October 24 Month Day Year 19 61		9. AGE (in years last birthday) 71 Years Months Days Hours Min.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Shipping - Shipyards		11. BIRTHPLACE (County & State, or foreign country) Estonia	
13. FATHER'S NAME Jon Lattik		14. MOTHER'S MAIDEN NAME Mary MN: Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or date of service) WW I		16. SOCIAL SECURITY NO. 213-01-8819		17. INFORMANT VAH, Baltimore 18, Maryland, Clinical Records, Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTERIOR MYOCARDIAL INFARCTION, RECENT(& OLD) DUE TO SEVERE CORONARY CALCIFIC SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Cerebral Encephalomalacia due to Cerebral Arteriosclerosis. Operations: L leg A/K 9/22/61; R leg AK 10/16/61 - Amputations.					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (1) (this hospital) attended the deceased from August 21, 1961 to October 24, 1961 that (2) (we) last saw the deceased alive on October 24, 1961 and that death occurred at 5:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Sebastian Russo M.D. 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTO. 18 MD. FT. HOWARD, MARYLAND		22b. DATE SIGNED 10/25/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-61		23c. NAME OF CEMETERY OR CREMATORY Holy Trinity(Orthodox)	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14		ADDRESS 6009 Harford Rd., Balto. 14		25a. REC'D BY REGISTRAR OCT 27 '61	
				25b. REGISTRAR'S SIGNATURE C. L. S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and within 24 hours after death, page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

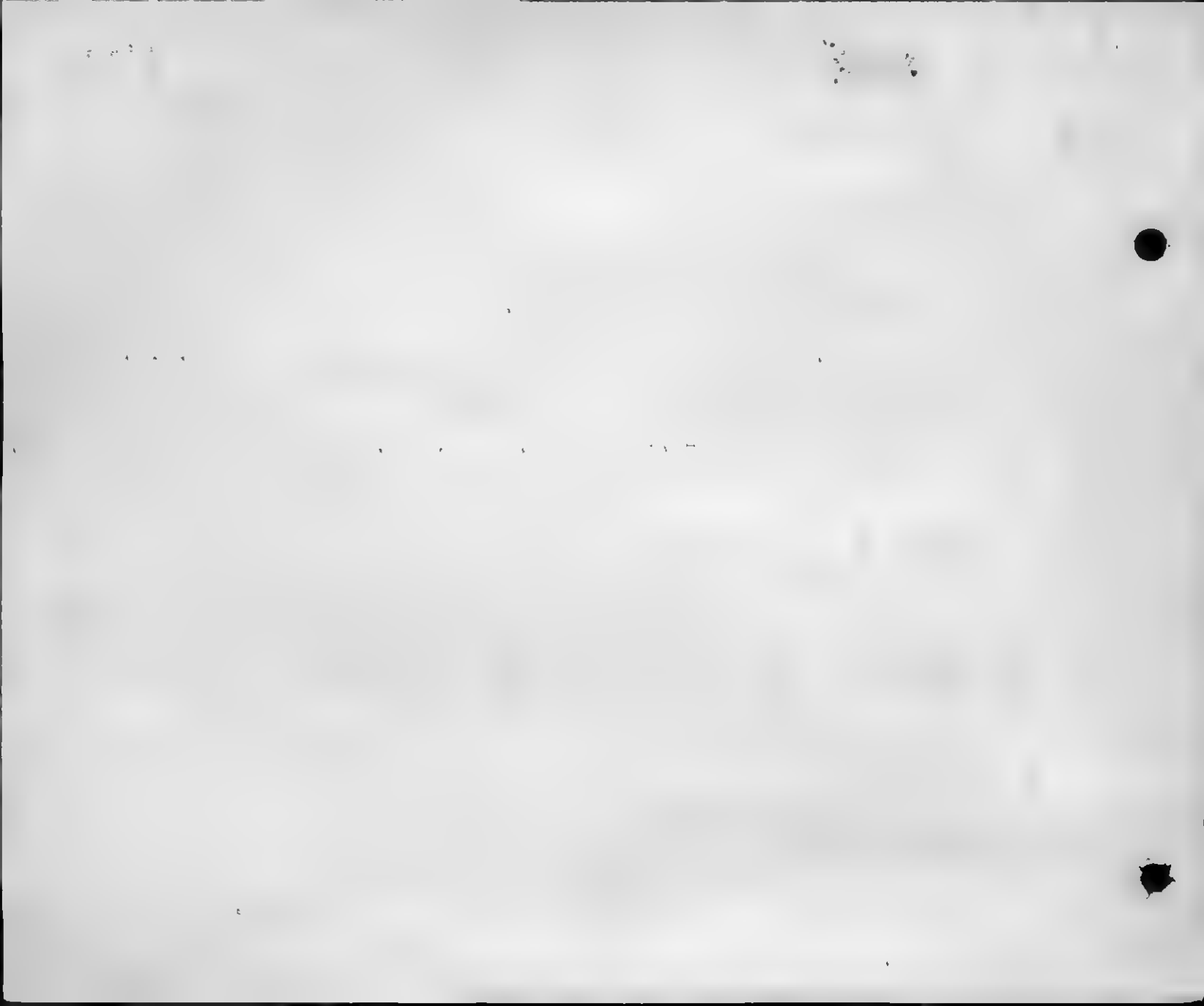
TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

137

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11126											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
<u>Middle River</u>						<u>1376 Wilson Point Road</u>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
<u>William James Lee</u>						<u>October 30th 19 61</u>					
5. SEX <u>male</u>						6. COLOR OR RACE <u>white</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>						8. DATE OF BIRTH					
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						<u>Aug. 26, 1904</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						9. AGE (In years last birthday)					
<u>The Martin Co.</u>						<u>57 yrs.</u>					
10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country)					
						<u>British Isles</u>					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<u>Ralph Lee</u>						<u>Ann Switzer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.					
						<u>212-01-3382</u>					
17. INFORMANT						Address					
						<u>Mr. George H. Lee 4216 Harford Terrace.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
<u>Drowning - accidental</u>											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH											
20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)											
<u>Pt. Fall from pier while fishing</u>											
20c. TIME OF INJURY Month, Day, Year											
Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED											
<u>10-27-61</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify)											
<u>Burial</u>											
22b. DATE THEREOF											
<u>11/1/61</u>											
22c. NAME OF CEMETERY OR CREMATORY											
<u>Moreland Mem Park</u>											
22d. LOCATION (City, town, or country) (State)											
<u>Baltimore, Maryland</u>											
23. FUNERAL DIRECTOR ADDRESS											
<u>Leonard J. Ruck 5305 Harford Road #14</u>											
24a. REC'D BY REGISTRAR											
<u>ACT 31 '61</u>											
24b. REGISTRAR'S SIGNATURE											
<u>Arthur S. Kraus</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11136 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11127
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>	
c. LENGTH OF STAY IN 1b <i>67 years</i>		d. STREET ADDRESS <i>Western Run Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Western Run Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Zachariah</i> First <i>Lee</i> Middle <i>Lee</i> Last		4. DATE OF DEATH <i>14 October</i> 14 <i>1961</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10 August 1894</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Western Run Rd. Cockeysville</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Edward Lee</i>		14. MOTHER'S MAIDEN NAME <i>Emma Mayers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>YES World War I</i>		16. SOCIAL SECURITY NO. <i>213-12-6330</i>	
17. INFORMANT <i>Wife - Alice Lee</i>		Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>A.S.C. V.D.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i> <i>over 15 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>14th Sept</i> 19 <i>61</i> , to <i>14th Sept</i> 19 <i>61</i> , that (I) (we) lost <i>saw the deceased alive on</i> <i>14th Sept</i> 19 <i>61</i> , and that death occurred of <i>1:20 P</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter T. Kees</i>		22b. DATE SIGNED <i>14 Oct 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		22d. ADDRESS <i>Cockeysville Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/18/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lough's</i>		23d. LOCATION (City, town, or county) (State) <i>Cockeysville, Balto. Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Chatman</i>		25a. REC'D BY REGISTRAR <i>Oct 15 '61</i>	
ADDRESS <i>1701 N 1st St. Balto. Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11128

11137

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1007 Longview Rd</u>				2. USUAL RESIDENCE (Where deceased lived. If Institutions: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balt</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1007 Longview Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry J.</u> Middle <u>Leppert</u> Last <u>Leppert</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 2, 1901</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Leppert</u>		14. MOTHER'S MAIDEN NAME <u>Rich</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-03-0070</u>		17. INFORMANT <u>Catharine Leppert</u>		Address <u>1007 Longview Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease (Atherosclerosis)</u> 420.1 DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21a. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a. m.</u> <u>p. m.</u>		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Oct 4, 1961</u>	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		1010 Longview Rd			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 7, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Max R. Kieffer</u>		ADDRESS <u>Catonsville 28-Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kieffer</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11138

11129

1 PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE NURSING HOME</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
				d. STREET ADDRESS <u>2810 HILLCREST AVE</u> #14			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>ALBERT R. LEHMAN</u>				4. DATE OF DEATH <u>OCT. 29, 61</u> 19			
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 8, 1893</u>	
9 AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>ASST. TO AUDITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BTO R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16 SOCIAL SECURITY NO. <u>—</u>		17 INFORMANT <u>MARY E. LEHMAN</u> Address <u>2810 HILLCREST AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>117.1</u> <u>Malignant Tumor Left Shoulder</u> DUE TO <u>Massive & Extensive</u> (b) <u>(Pathological Sections From Biopsy)</u> DUE TO <u>Arterio Sclerosis</u> (c) <u>En route</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <u>10/28/61</u> to <u>10/29/61</u> , that (I) <u>last</u> saw the deceased alive on <u>10/28/61</u> , and that death occurred <u>at P.M.</u> from the causes and on the date stated above							
22a SIGNATURE <u>W. E. McGroth</u>				22b DATE SIGNED <u>10/30/61</u>			
22c PHYSICIAN'S NAME (Type) <u>W. E. McGroth M.D.</u>				22d ADDRESS <u>1203 Frederick Rd (28)</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>NOV. 1, 1961</u>		23c NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		23d LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Charon</u> ADDRESS <u>3617 Chestnut Ave.</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. S. Hanna</u>	

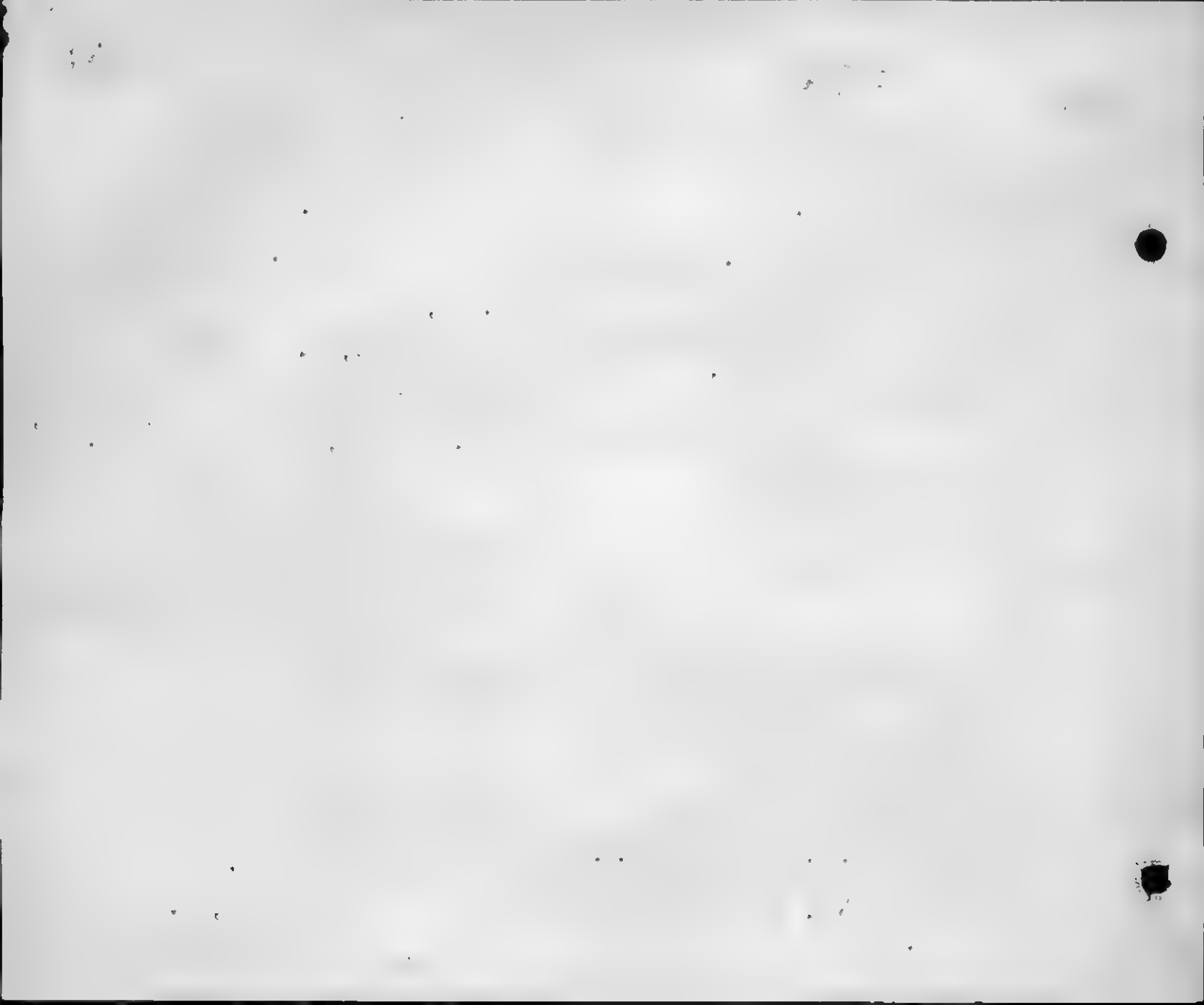
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
11141														
11130														
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Manor c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5902 Harford Ave.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Manor d. STREET ADDRESS 5902 Harford Ave.									
3. NAME OF DECEASED (Type or print) Eva M. Lirdner					4. DATE OF DEATH Oct. 31/61 Month 19 Day 19 Year 19									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1921 40 yrs.		9. AGE (In years last birthday) 40 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter					10b. KIND OF BUSINESS OR INDUSTRY Perfect Garment Co.					11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME Joseph Dailey					14. MOTHER'S MAIDEN NAME Catherine Kuester				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 212 16 0060					17. INFORMANT George A. Lindner, 5902 Harford Ave.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170x DUE TO Carcinoma of breast, right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 yrs. DUE TO 2 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. 19 p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept. 1959 to 10/31 , 19 61 , that (I) (was) last saw the deceased alive on 10/30 , 19 61 , and that death occurred at 3 P.M. from the causes and on the date stated above.										22a. SIGNATURE D. C. MacLaughlin M.D. D. C. MacLaughlin, M.D.				
22b. ADDRESS 4508 Edmondson Village Baltimore 29, Md.					22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D.					22d. DATE SIGNED Nov. 1 '61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Nov. 3/61					23c. NAME OF CEMETERY OR CREMATORY London Park				
23d. LOCATION (City, town or county) Baltimore 29, Md.					23e. (State) Md.					23f. (Country) USA				
24. FUNERAL DIRECTOR'S SIGNATURE Fitzke F.D.					24a. ADDRESS 4101 Edmondson Ave					24b. DATE NOV 1 '61				
24c. (City, town or county) Baltimore 29, Md.					24d. (State) Md.					24e. (Country) USA				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

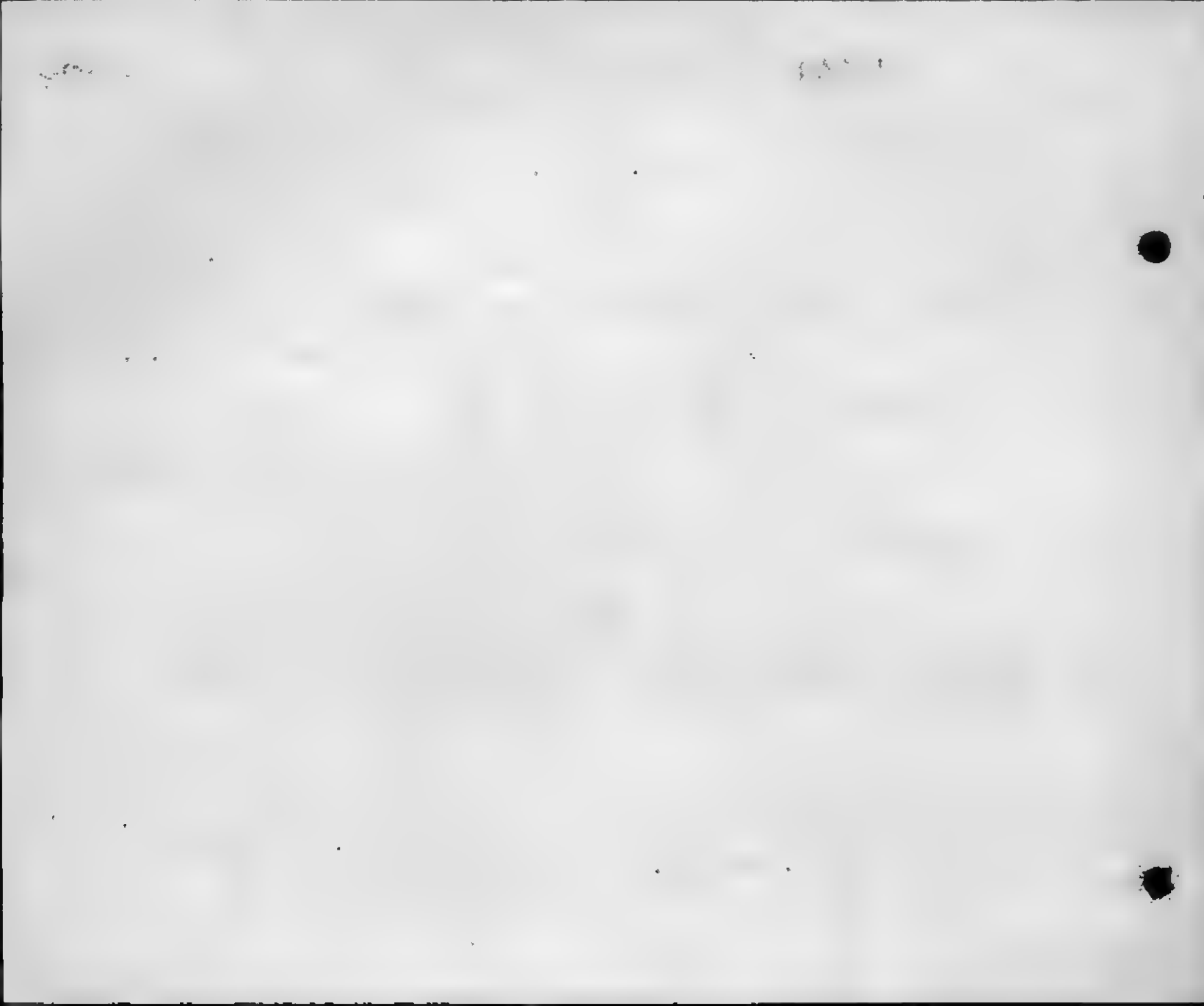
CERTIFICATE OF DEATH

11140

11131

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY N 16 <u>1 yr. 4 mos.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>California</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mill Valley</u> d. STREET ADDRESS <u>260 Cleveland Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>College Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence Hite Lineberger</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 13, 1882</u> <u>79</u> yrs.	9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect & Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Lancaster, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Levi Hite</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Courtright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>#571-32-2618</u>	
17. INFORMANT <u>Self</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>Generalized arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>4:20</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> <u>1960</u> to <u>Oct 18</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>Oct 18</u> <u>1961</u> and that death occurred at <u>7 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest C. Brown</u>		22b. DATE SIGNED <u>Oct. 19, 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u>		22d. ADDRESS <u>1101 N. Calvert Street</u> <u>Baltimore 2, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Oct. 20, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u> <u>md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. ...</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>...</u>	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11142

CERTIFICATE OF DEATH

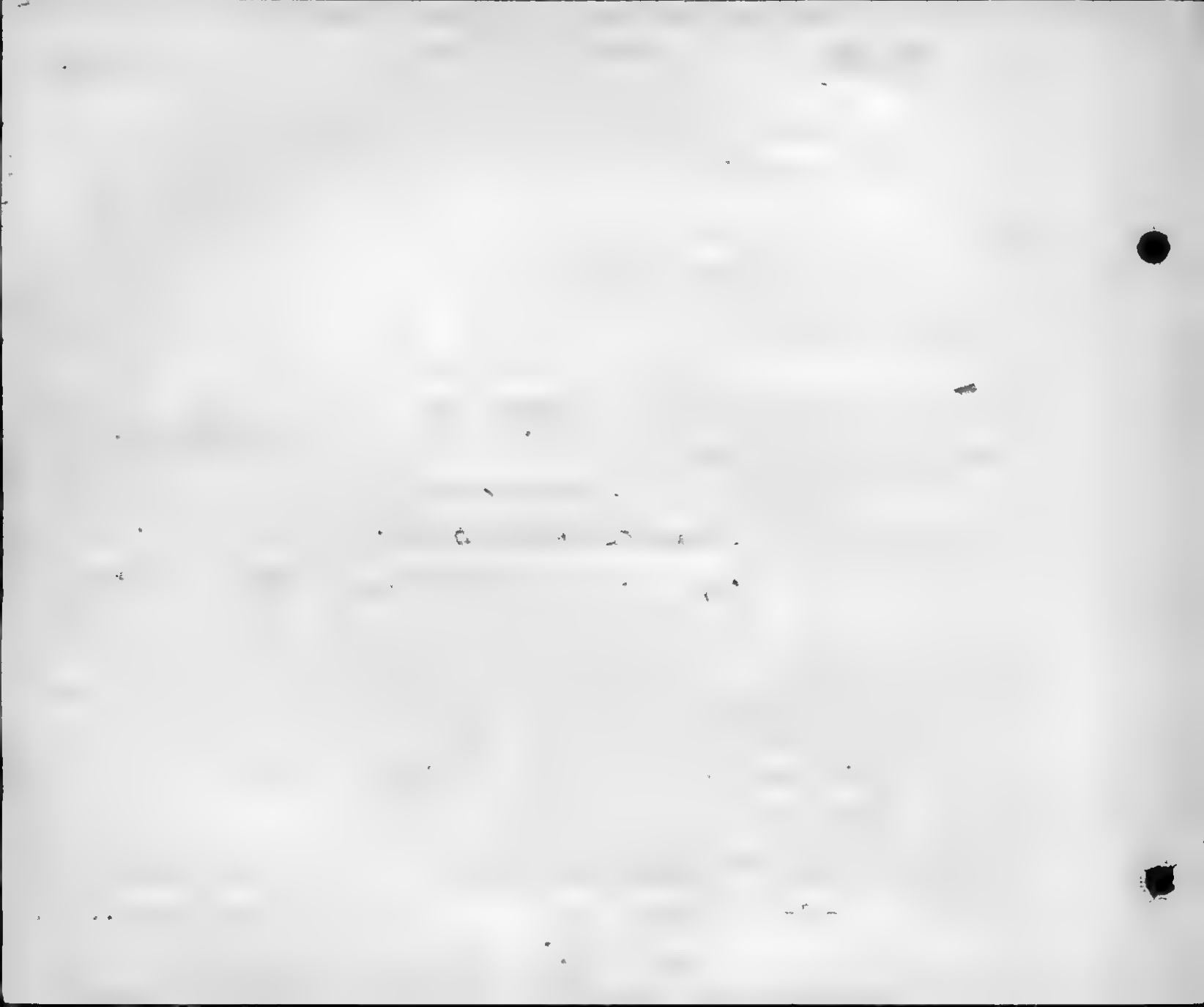
Reg. Dist. No. 11132

1. PLACE OF DEATH a. COUNTY <u>COUNTY of Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw Md.</u>			c. LENGTH OF STAY IN 1b <u>50 yrs +</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>JENNIE CORNELIA LINGHAM</u>			4. DATE OF DEATH Month Day Year <u>OCT 27 19 61</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 25 1874</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO CO- MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>ROBERT OSCAR BERRY</u>			
14. MOTHER'S MAIDEN NAME <u>ALBERTA GRAHAM</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Genevia Couplin Bradshaw, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complete Heart Block (since 11-18-60)</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had adenocarcinoma sigmoid colon removed at Johns Hopkins</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>11 months</u> <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air Rd. Kingsville Md.</u>	
20f. (City or town) <u>Kingsville</u>		(County) <u>Harford</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Jan 8, 1958</u> to <u>Oct 27, 1961</u> , that I last saw the deceased alive on <u>October 19, 1961</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bel Air Rd. Kingsville Md.</u> DATE SIGNED <u>Oct 28/61</u>					
ACTUAL SIGNATURE <u>Isabel H. McClinton</u>		PHYSICIAN'S NAME (Type) <u>Isabel H. McClinton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cem.</u>	
22d. LOCATION (City, town, or county) <u>Abingdon, Harford Co., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
M
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSVILLE</u> d. STREET ADDRESS <u>RT 321-X</u>											
3. NAME OF DECEASED (Type or print) First <u>LYTIA</u> Middle <u>E</u> Last <u>N</u>						4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1961</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 7, 1896</u>		9. AGE (In years last birthday) <u>64</u> Yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (Country & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME <u> </u>						14. MOTHER'S MAIDEN NAME <u> </u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO. <u>NONE</u>						17. INFORMANT <u> </u> Address <u> </u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEOPLASIA OF THE GASTRIC TRACT</u> DUE TO <u>CARCINOMA OF THE PANCREAS</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> DUE TO <u>METASTASIS TO THE LIVER</u> (c) <u> </u>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>4-30, 1941</u> to <u>10-15, 1961</u> , that (I) (we) last saw the deceased alive on <u>10-15-1961</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Ricardo Ibanez</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>RICARDO IBANEZ</u>						22d. ADDRESS <u>Spring Grove State Hospital</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>10-17-61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>LINTHICUM CHAPEL</u>			23d. LOCATION (City, town or county) (State) <u>CLARKSVILLE, Md.</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.C. Riggleman</u> ADDRESS <u>Ellicott City, Md.</u>						25a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 18 61</u>				25b. REGISTRAR'S SIGNATURE <u> </u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital on attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11144

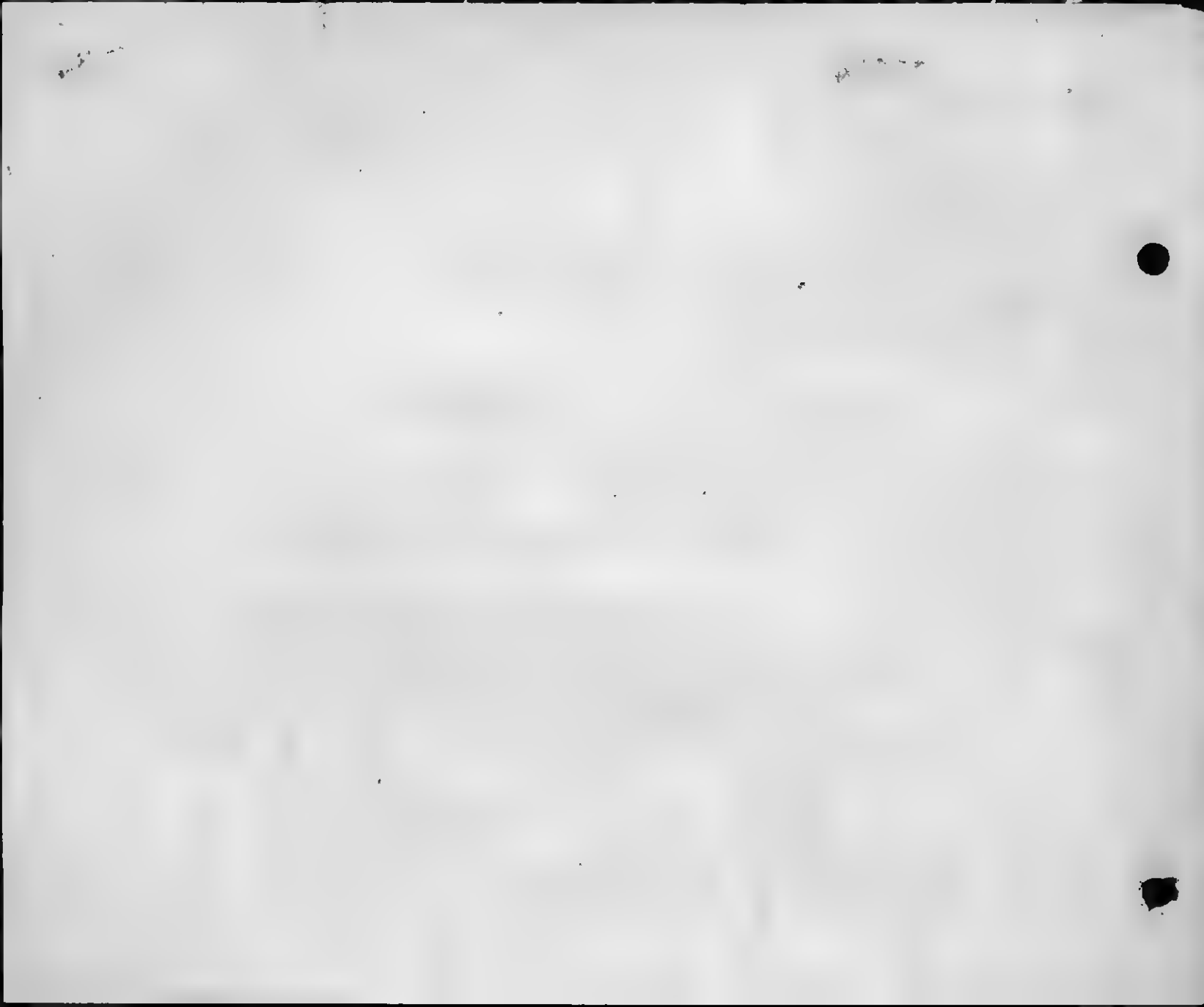
Item 22 11/17/61 iwk

CERTIFICATE OF DEATH

11134

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Maryland</u>	
c. LENGTH OF STAY IN TB <u>4yr7mth4dys</u>		d. STREET ADDRESS <u>1604 Heathwood Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jeremiah Clifton Lynch</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1874</u>
9. AGE (in years last birthday) <u>86</u> years		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>boilermaker</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Lynch</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>214-05-2978</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>March 11, 1961</u> to <u>Oct. 15, 1961</u> that (I) (we) last saw the deceased alive on <u>Oct. 15, 1961</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler, M. D.</u>		22b. DATE SIGNED <u>10-17-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/20/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board-Univ. of Md.</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR DATE <u>OCT 18 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11135

1. PLACE OF DEATH a. COUNTY 11145 Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 44 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2107 Dobler Avenue									
3. NAME OF DECEASED (Type or print) CHARLES E. MADERA		4. DATE OF DEATH Month October Day 19 Year 1961									
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1922								
9. AGE (In years last birthday) 39 yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Mn.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Mn.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE WORK 11. BIRTHPLACE (County & State, or foreign country) Freight Business Taylor Co West Virginia 12. CITIZEN OF WHAT COUNTRY U.S.A.	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Mn.								
13. FATHER'S NAME Joseph J. Madera		14. MOTHER'S MAIDEN NAME Lucille Tidghe									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 236-11-9596 17. INFORMANT Clin Rec VAH Baltimore Md Ft Howard Division									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES UNKNOWN									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus. Chronic Brain Syndrome											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 5, 1961 to Oct. 19, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 19, 1961 , and that death occurred at 5:23 p.m. from the causes and on the date stated above.											
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22b. DATE SIGNED 10-20-61 22d. ADDRESS VAH Baltimore Md - Ft Howard Division									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10-20-61									
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery 23d. LOCATION (City, town or county) (State) Clarksburg West Virginia									
25a. REC'D BY REGISTRAR Oct 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause									

Shipped to Davis-Haymond Funeral Home, Pike St., Clarksburg W.Va.

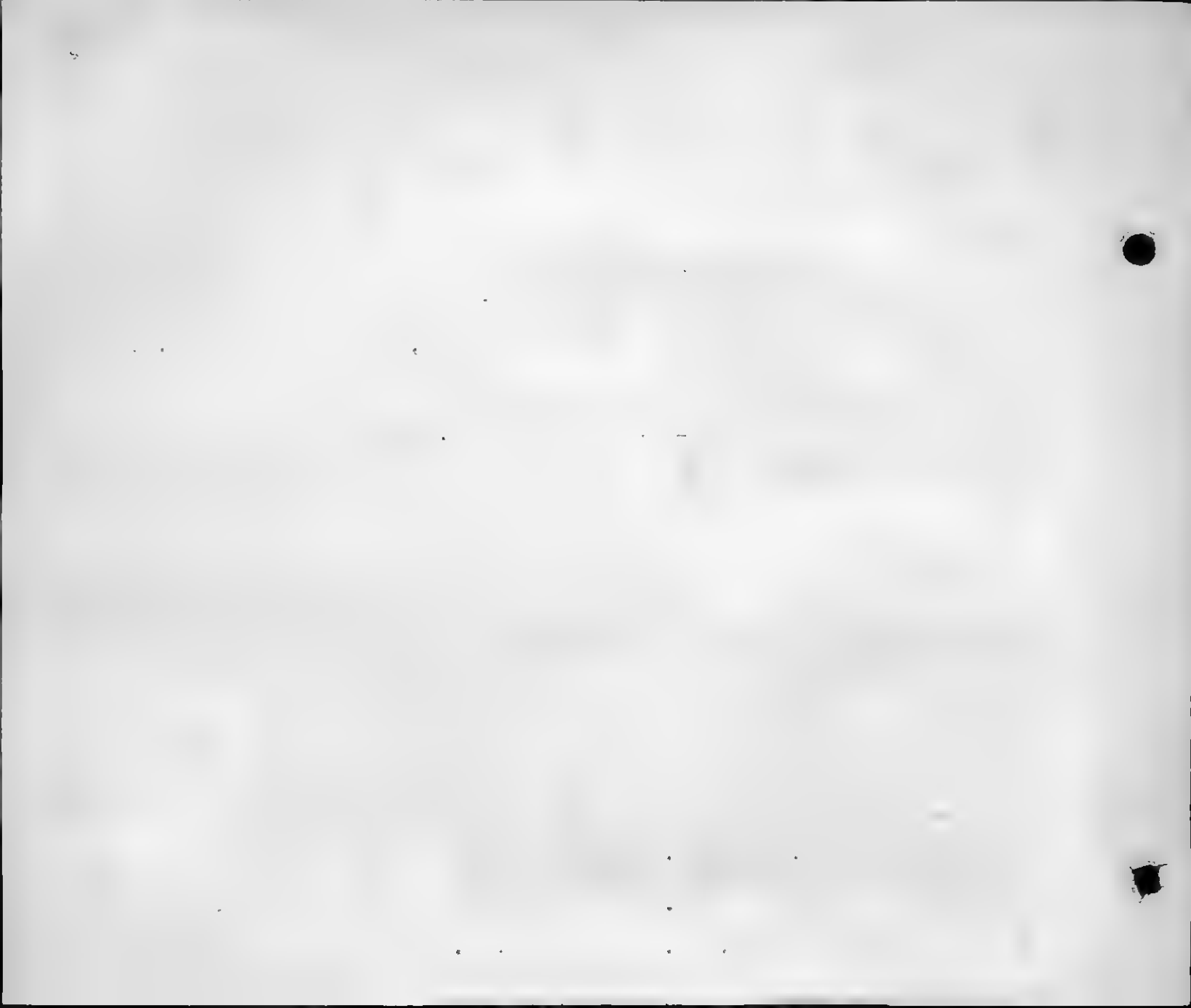
2000

1000

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN lb 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 238 Baltimore Avenue		d. STREET ADDRESS 238 Baltimore Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNEST Middle E Last MAFFEI		4. DATE OF DEATH Month October Day 30th Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1888
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Naples, Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Antonio Maffei		14. MOTHER'S MAIDEN NAME Marion Simon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-09-2913	
17. INFORMANT Daisy R. Maffei		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the descending colon with metastases to the liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) to lungs DUE TO (c) Arterio-sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 mos. 3-4 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-7 19 58 , to Oct 30 19 61 , that I last saw the deceased alive on Oct 30 19 61 , and that death occurred at 6:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eugene F. Nevy, M.D. 7001 Morningson Road 10/31/61 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D. Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/61	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR NOV 1 '61	
24b. REGISTRAR'S SIGNATURE W. L. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

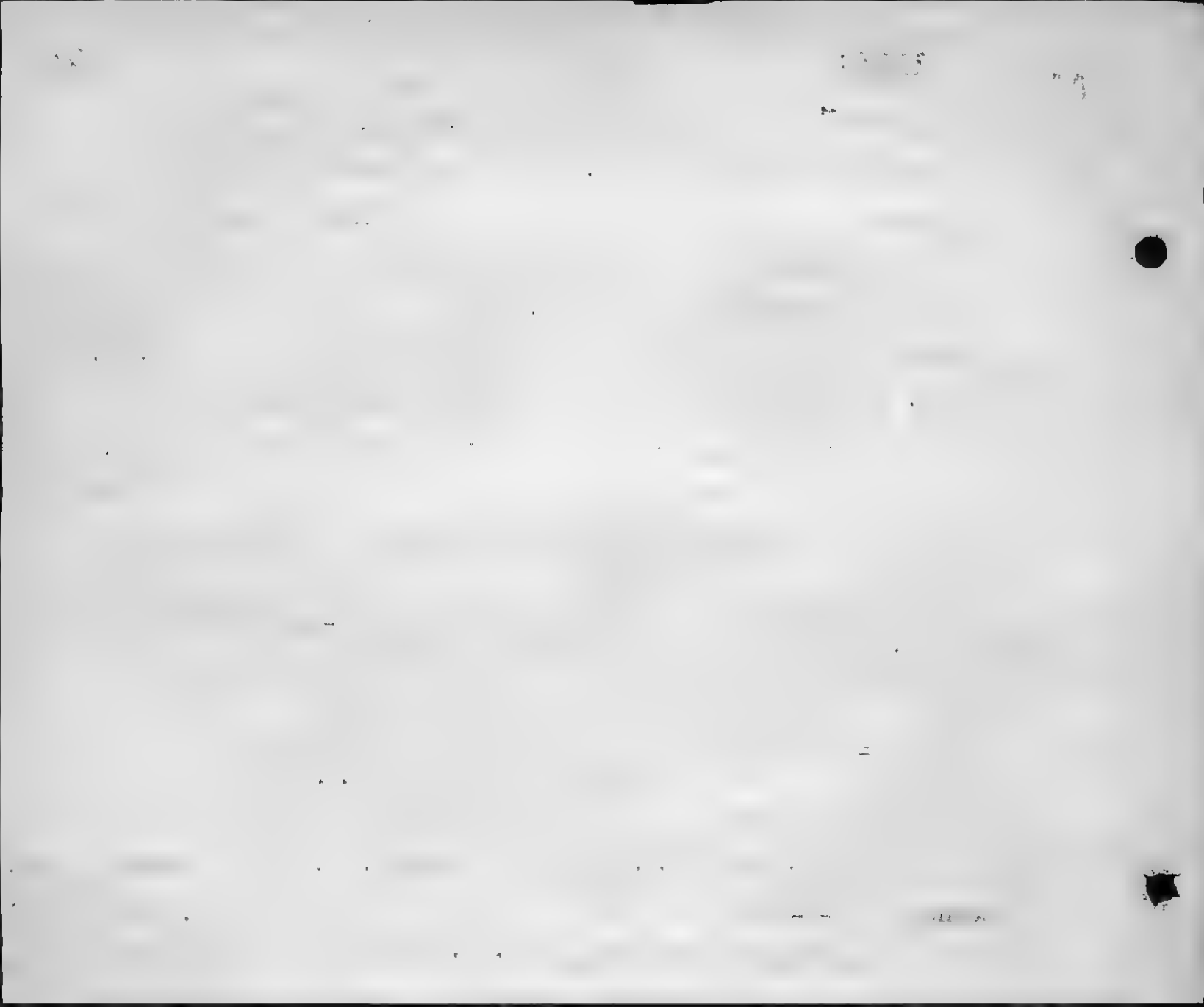
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11147

CERTIFICATE OF DEATH

11137

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS 2165 Hollins Street	
3. NAME OF DECEASED (Type or print) Michael Joseph MATZDORF		4. DATE OF DEATH 10 6 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Henry H. Matzdorf		14. MOTHER'S MAIDEN NAME Elizabeth Marie Touchard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Rosewood Records, Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO Acute bronchitis (malformation of superior maxillary bone with maximum connective tissue obliteration of nasal passage (naso-pharynx)) DUE TO nasal passage (naso-pharynx)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Influenza meningitis with complicating quadriplegia and and symptomatic epilepsy			
20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			
20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rosewood St., Tr. School, Owings Mills, Md.			
20d. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/23 19 54 to 10/6 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/6 19 61 , and that death occurred at 1:00 a.m. the causes and on the date stated above.			
22a. SIGNATURE Harry G. Butler		22b. DATE SIGNED 10/6/61	
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		22d. ADDRESS Rosewood St., Tr. School, Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-9-61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City, town or county) (State) Frederick Ave. Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny, Inc 1600 Hollins Balto. Md		25a. REC'D BY REGISTRAR OCT 9 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

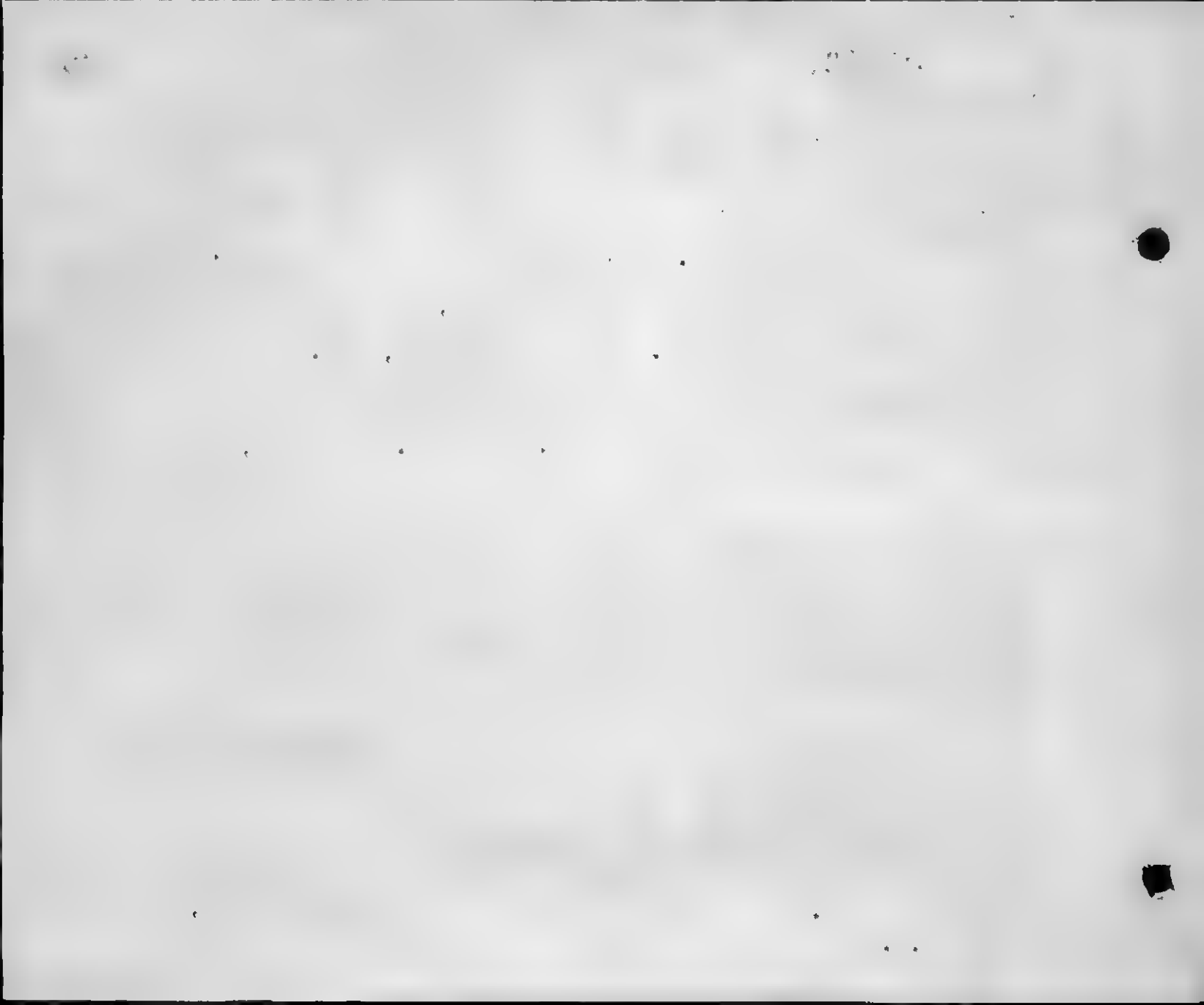
11148

CERTIFICATE OF DEATH

11138

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN TB Catonsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6520 Woodbridge Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 6520 Woodbridge Circle			
3. NAME OF DECEASED (Type or print) First Florence Middle J. Last McDonald		4. DATE OF DEATH Month Oct. Day 7/61 Year 19		5. SEX Female			
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1885			
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 6		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY May Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Parry		14. MOTHER'S MAIDEN NAME Catherine Burns			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Thomas J. McCartney, 6520 Woodbridge Circle			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Metastases squamous cell carcinoma of the floor of mouth DUE TO (b) 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Baltimore		20g. (County) Md.		20h. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 28, 1959</u> to <u>Oct 7, 1961</u>, that (I) (we) last saw the deceased alive on <u>Oct 6, 1961</u>, and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE George A. Knipp		22b. DATE SIGNED Oct 10 '61		22c. PHYSICIAN'S NAME (Type) George A. Knipp M.D.			
22d. ADDRESS 4116 Edmondson Ave		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10/61		23c. NAME OF CEMETERY OR CREMATORY New Cathedral			
23d. LOCATION (City, town or county) Baltimore 29, Md		23e. (State) Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Fitzke F.D.		24b. ADDRESS 4101 Edmondson Ave		25a. REC'D BY REGISTRAR OCT 10 '61			
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		25c. DATE OCT 10 '61					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11149

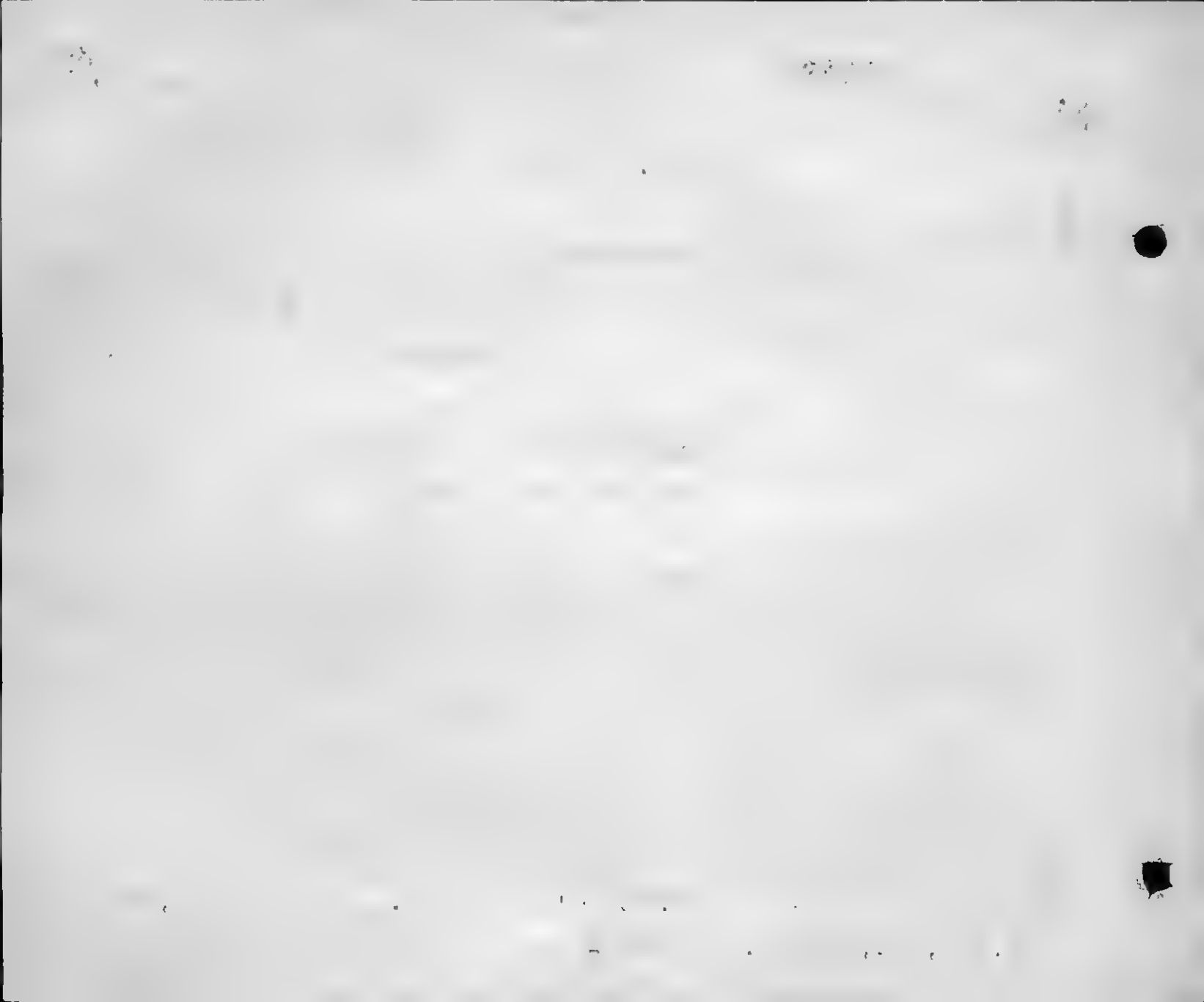
11139

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY in 1b <u>lmo. 16 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>615 CHESTNUT AVE</u> d. STREET ADDRESS <u>BALTIMORE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First Middle Last <u>A. McKENZIE</u>			4. DATE OF DEATH Month Day Year <u>10 30 1961</u>		
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>10-15-82</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Massachusetts</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>William McKenzie</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Kate Healy</u> 16. SOCIAL SECURITY NO. <u>212-03-8208</u> 17. INFORMANT <u>Records: Spring Grove State Hospital</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> (b) <u>Arteriosclerotic cardiovalvular disease</u> (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4221</u> days <u>4221</u> years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> , 19 <u>61</u> , to <u>10-30</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>61</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Maurice J. Van Besien</u> 22c. PHYSICIAN'S NAME (Type) <u>MAURICE J. VAN BESIE</u>			22b. DATE SIGNED <u>10-30-61</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Maryland</u>		
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>BURIAL</u> <u>11-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Church Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Havre de Grace, Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street-Zone 2</u> ADDRESS	
25a. REC'D BY REGISTRAR <u>DATE NOV 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11150

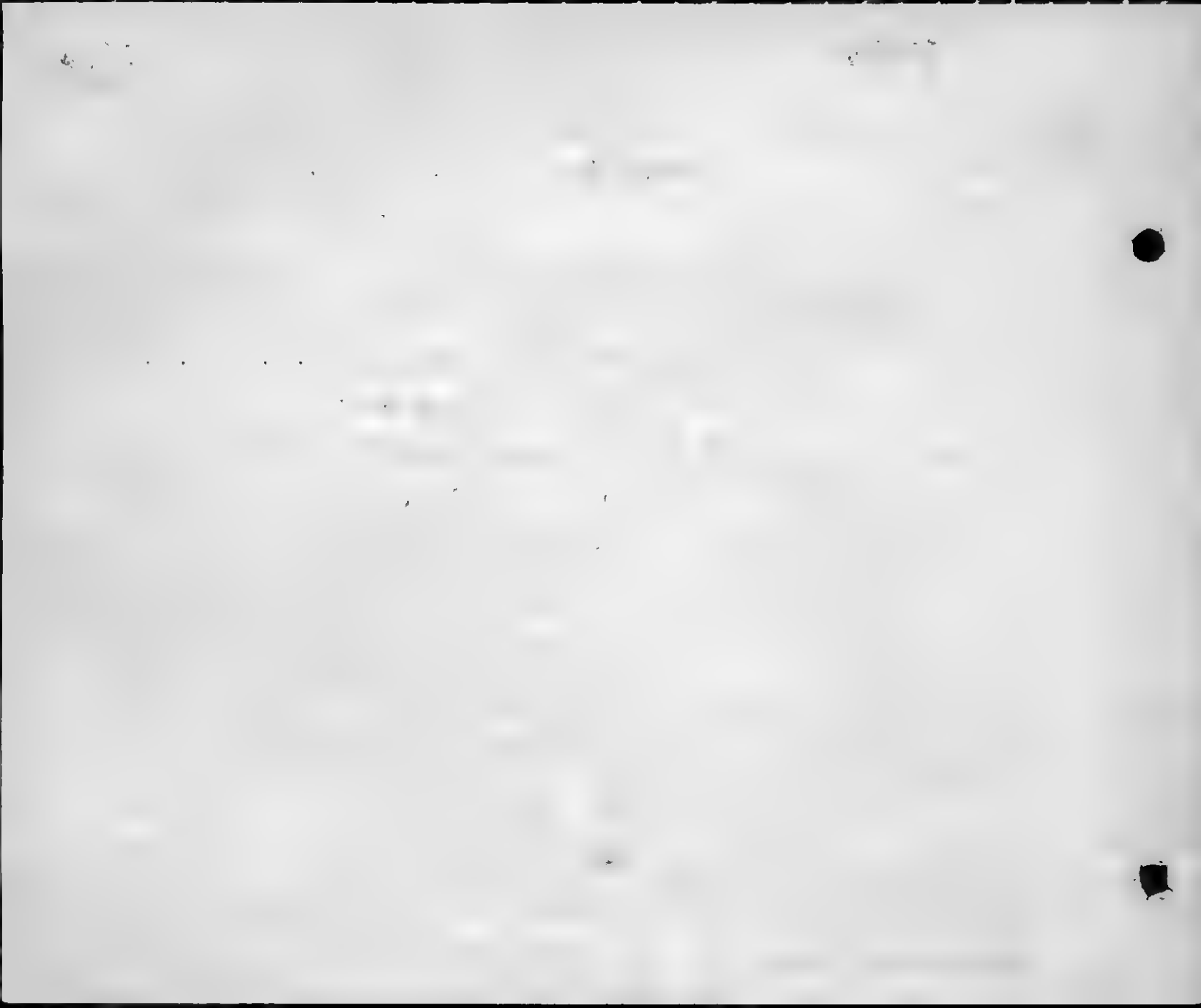
11140

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.			
c. LENGTH OF STAY in 1b 6yr5mth21dys				d. STREET ADDRESS 432 Ethan Allen Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL							
3. NAME OF DECEASED (Type or print)		First William Middle Warren Last McQueeney		4. DATE OF DEATH Month OCT. Day 14 Year 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1903	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William McQueeney				14. MOTHER'S MAIDEN NAME Mary Carroll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 579-10-2581		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Malignancy 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Tonsillar Pillar DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 17, 1955 to 10/14/61 , 19 61 , that (I) (we) last saw the deceased alive on 10/14 , 19 61 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ricardo Ibanez M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10/15/61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Ricardo Ibanez				22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Fort Myer Va	
24. FUNERAL DIRECTOR'S SIGNATURE Frank Gevers Sons Co				ADDRESS 3605-14 St NW		25a. REC'D BY REGISTRAR OCT 17 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Wash. 10 C



TO IF **AL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within **hours** after death. Page 4 may be obtained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11151

CERTIFICATE OF DEATH

11141

Items 3 & 13 Film G297 10/23/61 mh

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>Medell</u> Last <u>MEYER</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12. 1. 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>47</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH MEYER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA GABRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>717-05-4821</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leucemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lung abscess</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>8. 2. 1961</u> to <u>10. 15. 1961</u> ; that (I) (we) last saw the deceased alive on <u>10. 15. 1961</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. Newcomer</u>		22b. DATE SIGNED <u>10.15.1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-18-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Mem. Annapolis Md.</u>	23d. LOCATION (City, town, or county) _____ (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 17 '61</u>	
ADDRESS <u>San Annapolis Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u>	

MEDICAL CERTIFICATION



TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12

M

I

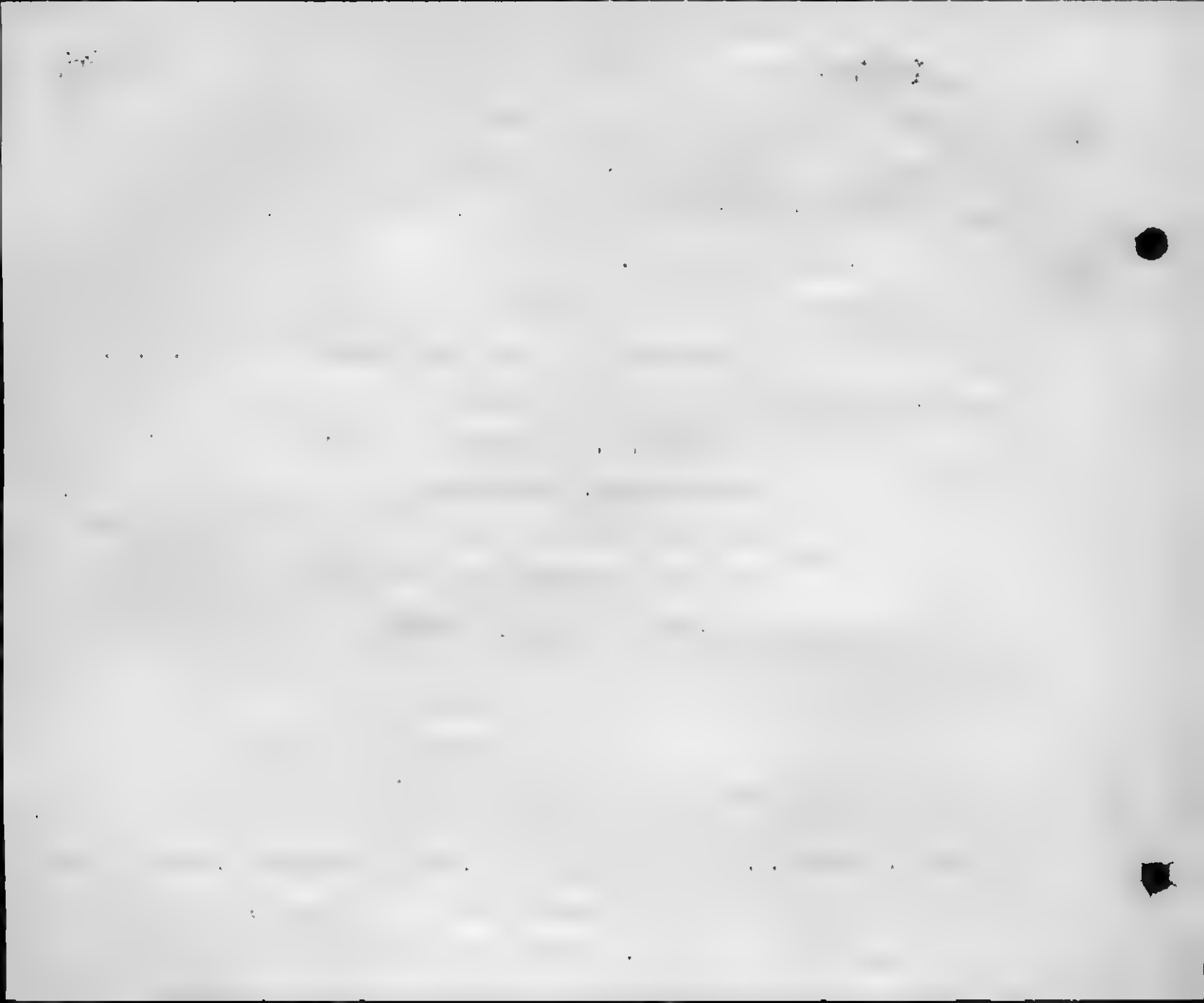
11152

11142

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 18 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 5 d. STREET ADDRESS 928 N. Washington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH H. MEIFARTH		4. DATE OF DEATH Month October Day 10 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 12, 1888
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gardening	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry F. Meifarth		14. MOTHER'S MAIDEN NAME Wilhelmina Hofer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 217-22-7597	
17. INFORMANT Clinical Records, VAH, Baltimore, 18, Maryland		18. ADDRESS Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE (b) PULMONARY EMPHYSEMA (c) CARCINOMA OF PROSTATE WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS UNKNOWN 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Transrectal biopsy-Adenocarcinoma- Operation 9/27/61		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 22, 1961 , to October 10, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 10, 1961 , and that death occurred at 4:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 10/10/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO. 18, MARYLAND, FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-13-1961	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Jerome Cvach, 900 N. Chester St., Baltimore, Md.		25a. REC'D BY REGISTRAR OCT 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11153

11143

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Road Sparks Maryland				d. STREET ADDRESS York Road Sparks Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Walter Dickinson Merryman				4. DATE OF DEATH Month 10 -Day 16 -Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-20-1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Contractor		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas H. Merryman				14. MOTHER'S MAIDEN NAME Martha Garber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown No				16. SOCIAL SECURITY NO. 215-24-0917		17. INFORMANT W. Leroy Merryman	
				Address 2345 York Rd Md.		Timmonium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1945 to 10/16 , 1961 , that (I) (we) lost saw the deceased alive on 10/15 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. M. France M.D.				22b. DATE SIGNED 10/18/61		22c. PHYSICIAN'S NAME (Type) A. M. FRANCE	
22d. ADDRESS PARKTON, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-61		23c. NAME OF CEMETERY OR CREMATORY Foster's		23d. LOCATION (City, town, or county) (State) Hereford, Monkton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				25a. REC'D BY REGISTRAR DATE OCT 20 '61		25b. REGISTRAR'S SIGNATURE <i>Charles S. French</i>	

of

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11154

CERTIFICATE OF DEATH

11144

Item 23b, File 6292 70/20/61-11144

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fort Howard

c. LENGTH OF STAY IN 1b

51 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Veterans Administration Hospital

3. NAME OF DECEASED
(Type or print)

First
GEORGE

Middle
--

Last
MILLER

8. DATE OF BIRTH

January 2, 1888

9. AGE (In years last birthday)

73 yrs.

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sand Blaster

10b. KIND OF BUSINESS OR INDUSTRY

Navy Yard

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Miller

14. MOTHER'S MAIDEN NAME

Lizzie Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Yes WW I

16. SOCIAL SECURITY NO

219-38-7328

17. INFORMANT Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md-FORT HOWARD DIVISION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

PULMONARY INFARCTION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

BRONCHOPNEUMONIA

PULMONARY HYPERTENSION

PULMONARY INFILTRATION OF UNKNOWN ETIOLOGY

INTERVAL BETWEEN ONSET AND DEATH
2 days

Years

Years

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Osteoarthritis. Emphysema of lungs. Stricture of esophagus

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Hour a.m. p.m.
19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that ☒ (this hospital) attended the deceased from August 23, 1961 to Oct. 13, 1961, that ☒ (we) last saw the deceased alive on Oct. 13, 1961, and that death occurred at P.M. from the causes and on the date stated above.

22a. SIGNATURE

Arthur T. Faulk

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED
10/14/61

22c. PHYSICIAN'S NAME (Type)

ARTHUR T. FAULK, M.D.

VAH Baltimore, Md-FORT HOWARD DIVISION

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE OF

Oct. 17, 1961

23c. NAME OF CEMETERY OR CREMATORY

Baltimore National

23d. LOCATION (City, town or county)

Baltimore

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

Howard A. Evans Funeral Home

ADDRESS

1100 S. Charles St. Baltimore, Maryland

25a. REC'D BY REGISTRAR

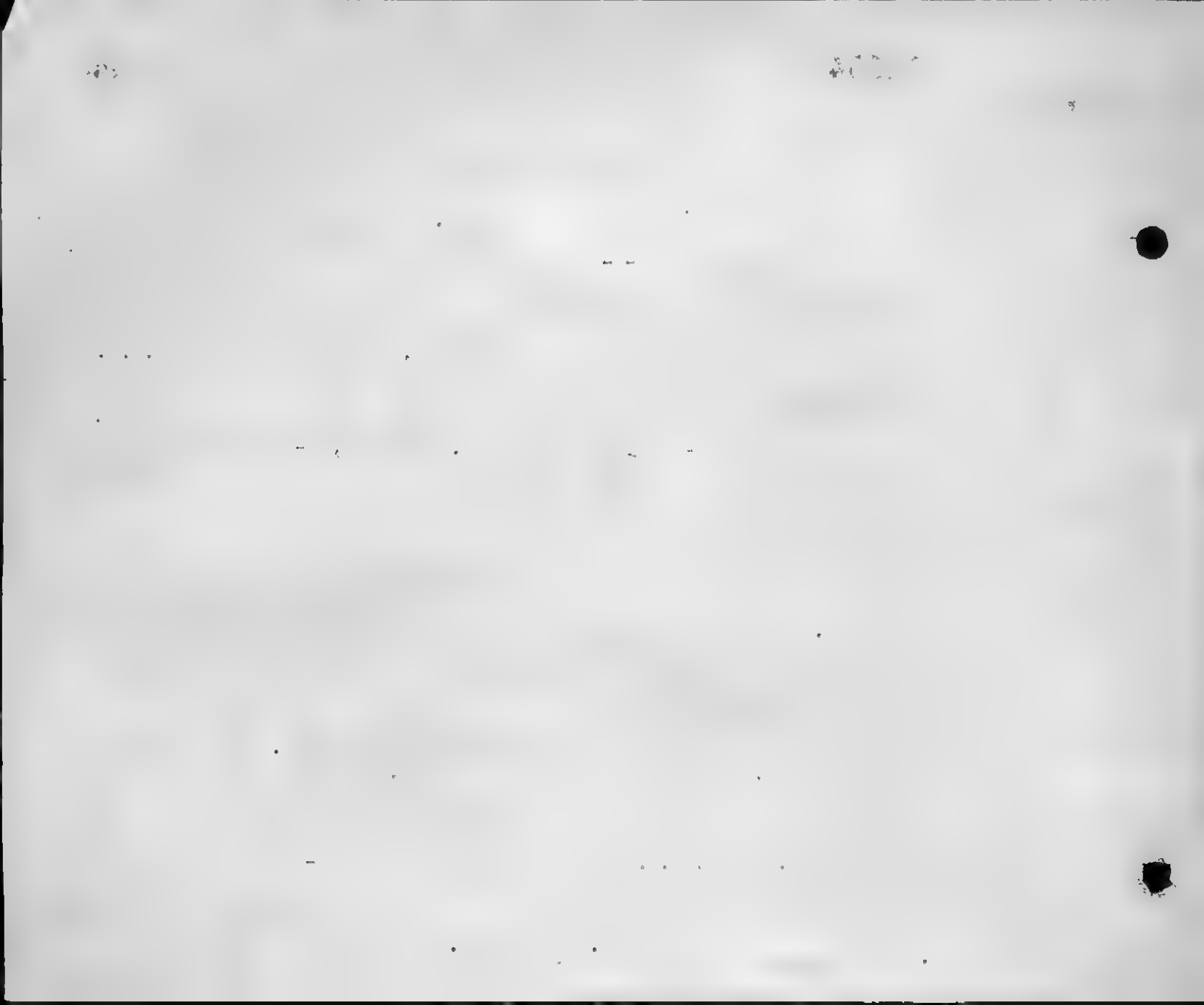
OCT 17 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

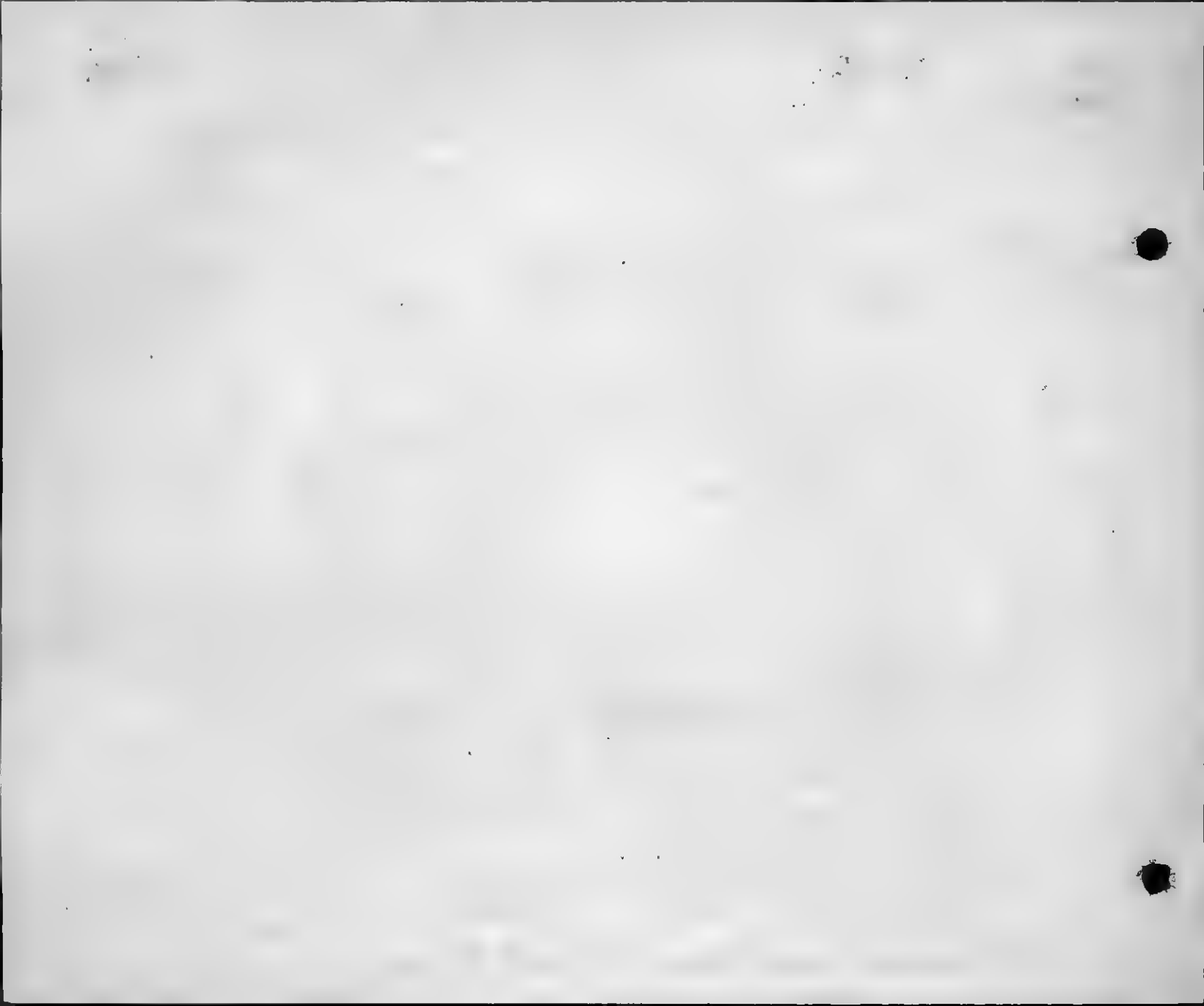
11155

CERTIFICATE OF DEATH

11145

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY in lb 28 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3719 Edmondson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle P. Last Milligan				4. DATE OF DEATH Month October Day 2 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1904	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Milligan				14. MOTHER'S MAIDEN NAME Anna Crouse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150X DUE TO (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 4, 1961 to Oct. 2, 1961 , that (I) (we) last saw the deceased alive on Oct. 2, 1961 , and that death occurred at 11:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar, M. D.				M.D. _____		22b. DATE SIGNED 10-2-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 4 1961		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) old Frederick Road	
24. FUNERAL DIRECTOR'S SIGNATURE Krause Funeral Home 1216 Schaub St				25a. REC'D BY REGISTRAR DATE OCT 6 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11156

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11146

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>50 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>303 Sollers PT. Rd.</u>		d. STREET ADDRESS <u>303 Sollers PT. Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Camilla</u> Middle <u>NEAL</u> Last		4. DATE OF DEATH <u>OCTOBER</u> Month <u>16</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 12, 1873</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR <u>5</u> Months <u>15</u> Days <u>-</u> Hours <u>-</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private family Cambridge, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Ross</u>		14. MOTHER'S MAIDEN NAME <u>Louise Washington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Louise Steeds 303 Sollers PT. Rd.</u>	
17. INFORMANT <u>Louise Steeds</u> Address <u>303 Sollers PT. Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u>15 yrs</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>45</u> , to <u>Oct 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>October 16</u> , 19 <u>61</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>140 Oak Avenue</u> DATE SIGNED <u>10-16-61</u> ACTUAL SIGNATURE <u>William C. Wade</u> M.D. PHYSICIAN'S NAME (Type) <u>William C. Wade</u> <u>DUNDALK 22, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-20-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	22d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR <u>OCT 19 1961</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible handwriting]

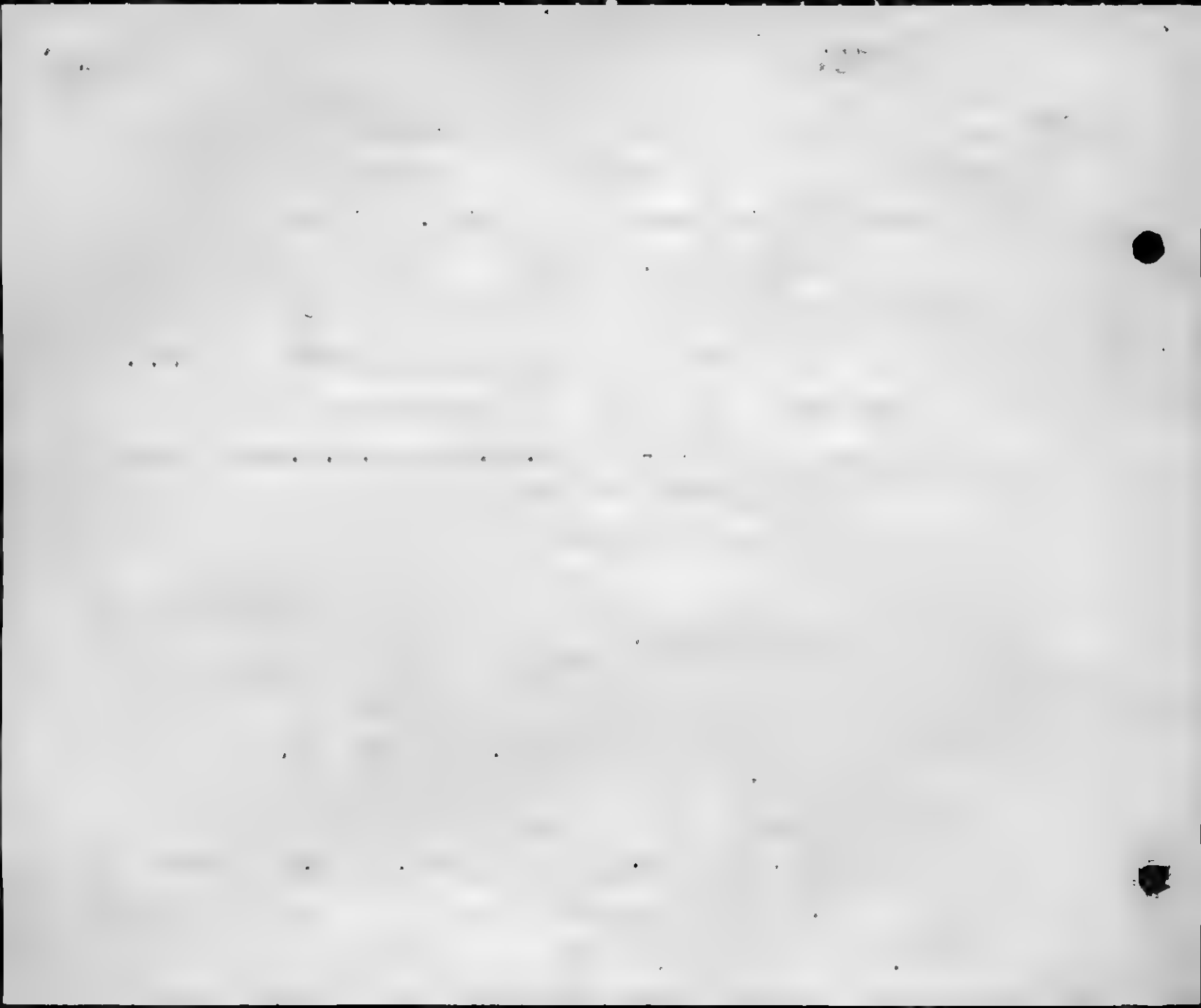
10. 10. 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11157
11147
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1011 W. North Avenue	
3. NAME OF DECEASED (Type or print) FRANK J. NOEL First Middle Last		4. DATE OF DEATH OCTOBER 7 1961 Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/98 Last First Middle
9. AGE (in years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Noel		14. MOTHER'S MAIDEN NAME Lavinia Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 218-14-7174	
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS BRONCHO PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA. ARTERIOSCLEROSIS.			
19. INTERVAL BETWEEN ONSET AND DEATH 4 DAYS			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Oct. 4 1961 to Oct. 7 1961 that (we) last saw the deceased alive on Oct. 7 1961 , and that death occurred at 2:15AM from the causes and on the date stated above.			
22a. SIGNATURE Charles E. Rowan M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN, M.D.		22d. ADDRESS VAH, BALTO. MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 11, 1961	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS 802 Madison Avenue Baltimore, Maryland		25a. REC'D BY REGISTRAR OCT 10 '61	
25b. REGISTRAR'S SIGNATURE Charles R. Law			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11158

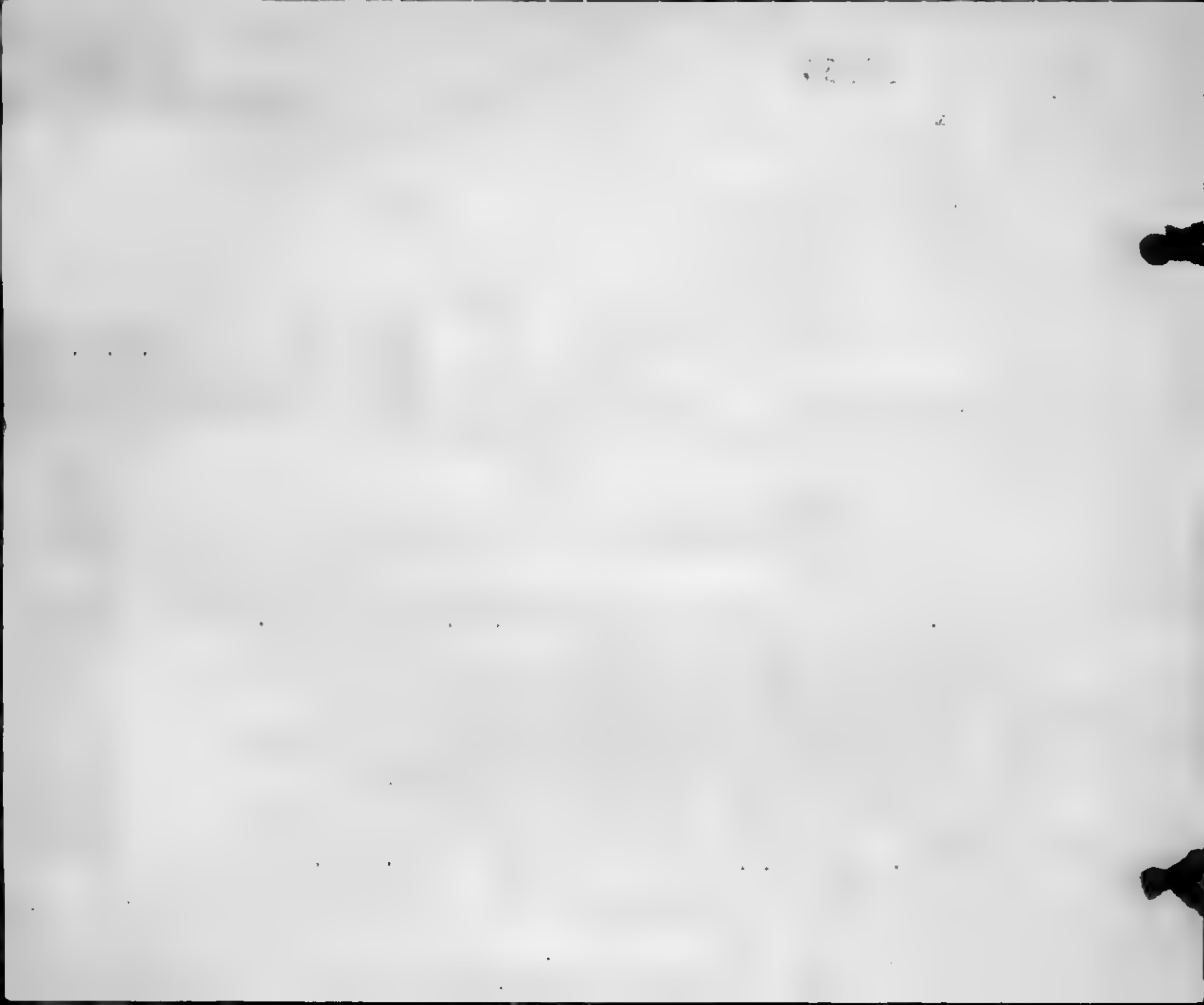
11148

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>35 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>11</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge 27</u> d. STREET ADDRESS <u>2116 Church Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN PAIMER</u>		4. DATE OF DEATH Month Day Year <u>October 11 1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 4, 1894 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Middleville, Georgia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lather Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. _____ 17. INFORMATION <u>Clinical Records VAH, Baltimore 18, Maryland</u> <u>Fort Howard Division</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (a), stating the underlying cause last. (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Anemia. Hypertensive Cardiovascular Disease. Rt. Inguinal Hernia.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 6, 1961</u> to <u>October 11, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 11, 1961</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Crahan</u> 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>		22b. DATE SIGNED <u>10/12/61</u> 22d. ADDRESS <u>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore Maryland</u> ADDRESS _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips, 1808 N. Monroe St. Balto. 17</u>		25a. REC'D BY REGISTRAR <u>UG 16 61</u> 25b. REGISTRAR'S SIGNATURE <u>William E. Evans</u>	

Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11159

11149

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 1b

11yr7mth9dys

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

SPRING GROVE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

College Park, Maryland

d. STREET ADDRESS

4805 Calvert Road

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

First

Julian

Middle

IV

Last

I. Palmore

4. DATE OF DEATH

Month

Oct

Day

8,

Year

19 61

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Jan. 14, 1882

9. AGE (In years last birthday)

79 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

chemist

10b. KIND OF BUSINESS OR INDUSTRY

Government food industry

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

unknown

16. SOCIAL SECURITY NO. 17. INFORMANT

unknown

Records: SPRING GROVE STATE HOSPITAL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

422.1 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

Acute Cardiac FAILURE

ARTERIOSCLEROSIS

CARDIO-VASCULAR DISEASE

INTERVAL BETWEEN ONSET AND DEATH

Minutes

HOURS YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 28, 1949, to Oct. 8, 1961, that (I) (we) last saw the deceased alive on Oct 8, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

GERALD E. WEINSTEIN

M.D.

ATTENDING PHYS. ☐

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED

10/8/61

22d. ADDRESS

SPRING GROVE STATE HOSPITAL Catonsville 23, Maryland

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)

Transportation Oct 11, 1961 Cartersville

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

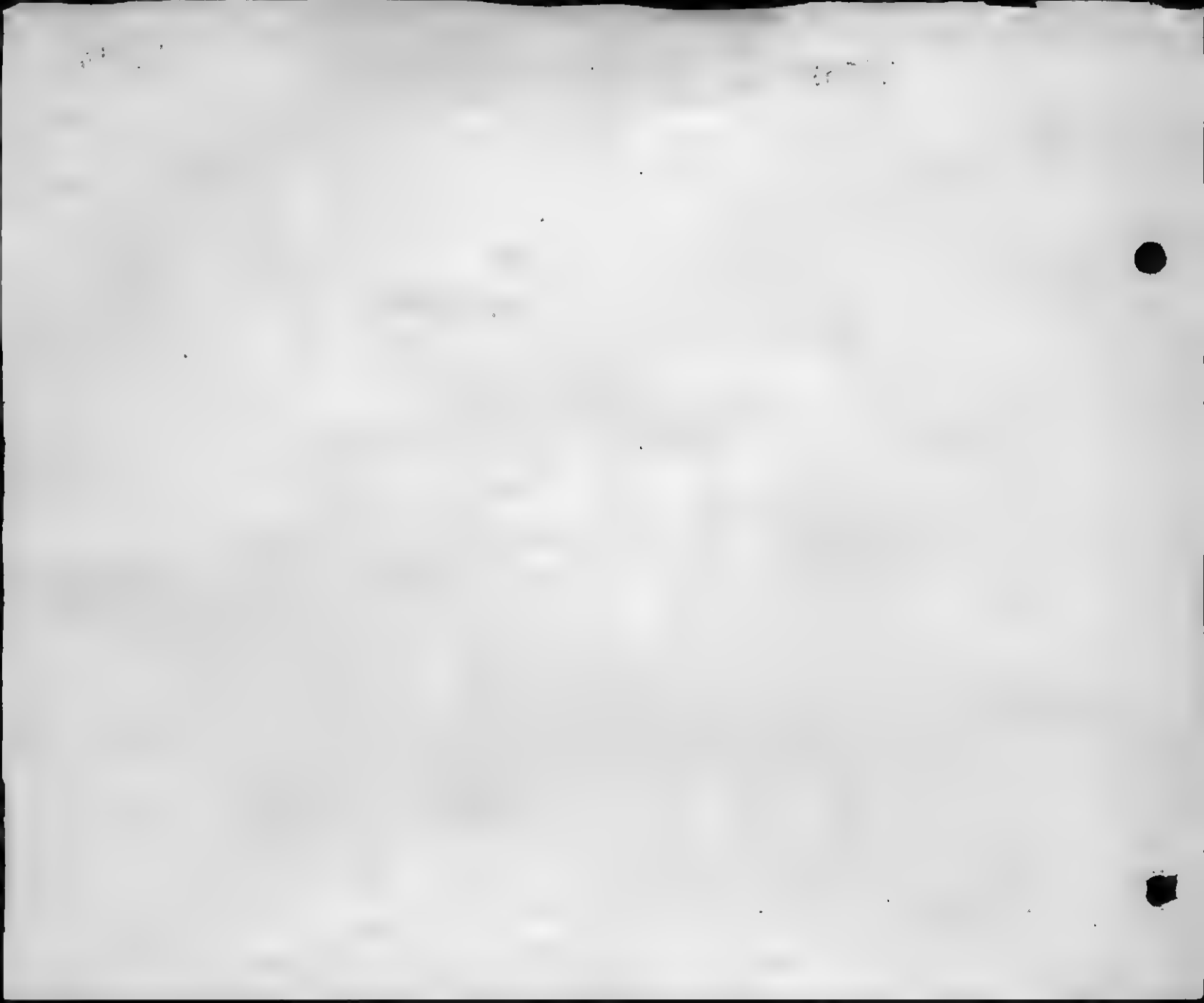
25a. RECEIVED BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11160					11150				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard					b. COUNTY Maryland				
c. LENGTH OF STAY in 1b 61 Days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7115 Chambers Road, Baltimore 14				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 7115 Chambers Road				
3. NAME OF DECEASED (Type or print) ANTON					4. DATE OF DEATH October 11 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH April 5, 1907 54 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger					10b. KIND OF BUSINESS OR INDUSTRY City Fire Department Baltimore, Maryland				
11. BIRTHPLACE (County & State, or foreign country) U. S. A.					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Rudolph Patek					14. MOTHER'S MAIDEN NAME Antonette Tomasek				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/dates of service) Yes WW II					16. SOCIAL SECURITY NO. 218-01-6302				
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, UNIVERSALIS DUE TO BRONCHOGENIC CARCINOMA, RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)				
20c. TIME OF INJURY Hour a.m., p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from August 11, 1961 to October 11, 1961 , that (X) (we) last saw the deceased alive on October 11, 1961 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.					22a. SIGNATURE Leonard J. Ruck M.D. 22b. DATE SIGNED 10/12/61				
22c. PHYSICIAN'S NAME (Type) VAH, BALTIMORE, MARYLAND, FT. HOWARD DIVISION					22d. ADDRESS Baltimore National Cem. Baltimore 28, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 10/16/61				
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.					23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck & Sons, 5305 Harford Rd., Balto. 14 Md.					25a. REC'D BY REGISTRAR OCT 13 '61				
25b. REGISTRAR'S SIGNATURE Charles S. K...									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

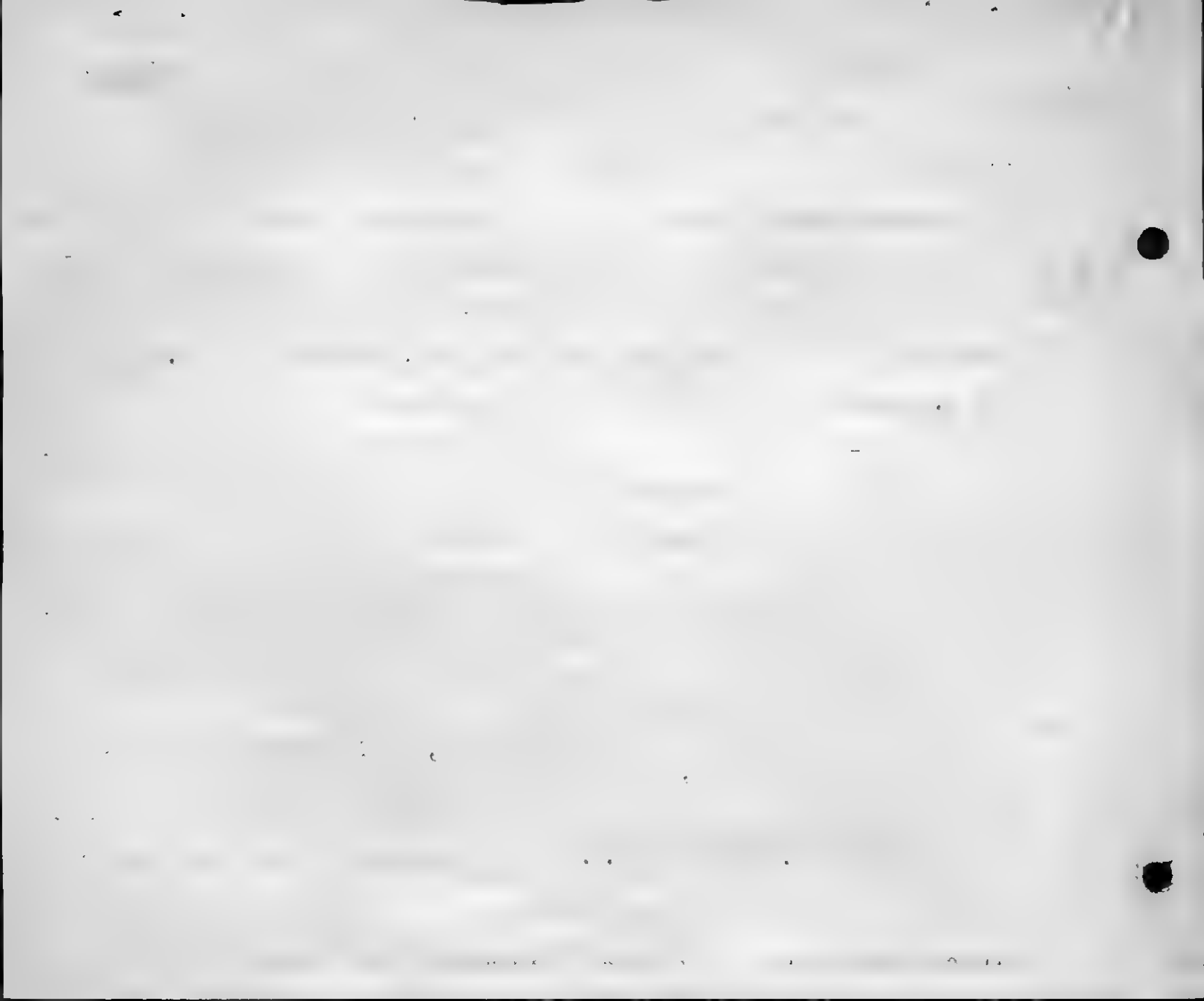
11161

CERTIFICATE OF DEATH

11151

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>12 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3230 Ravenwood Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>--</u> Last <u>REINHARD</u> 4. DATE OF DEATH <u>October 16 19 61</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 6, 1893</u> 9. AGE (in years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assemblyman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Mfg Co Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>John G. Reinhard</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-1</u> 16. SOCIAL SECURITY NO. <u>WW-1</u>		14. MOTHER'S MAIDEN NAME <u>Louise Wagner</u> 17. INFORMANT <u>Clin Rec VAH Baltimore Md Ft Howard Division</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 4, 1961</u> to <u>October 16, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 16, 1961</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel R. Zoll</u> M.D.		22b. DATE SIGNED <u>10-16-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Daniel R. Zoll</u> M.D.		22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u>		25a. REC'D BY REGISTRAR <u>OCT 19 61</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

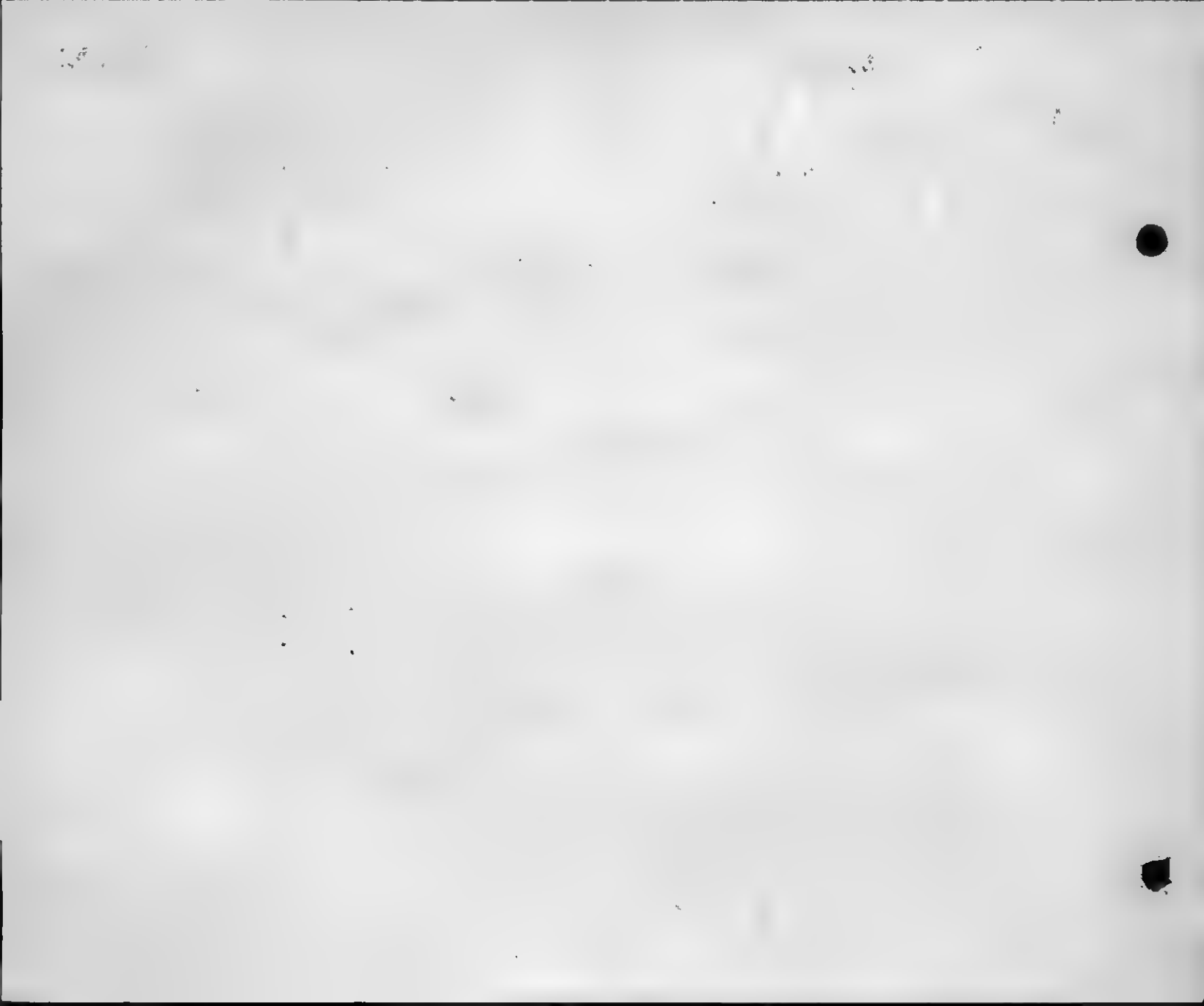
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11162

11152

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3704 CASSEN RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balti. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> d. STREET ADDRESS <u>3704 CASSEN RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK S. RIDGAWAY</u> First Middle Last 4. DATE OF DEATH <u>OCT. 3, 1961</u> Month Day Year		5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JAN. 15, 1880</u> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER, HARRY S. SCOTT PRINTING Co.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>SAMUEL S. RIDGAWAY</u> 14. MOTHER'S MAIDEN NAME <u>ANIE H. SNEAD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>212-035309A</u> 17. INFORMANT <u>MISS ETHEL G. RIDGAWAY</u> Address <u>3704 CASSEN RD. RANDALLSTOWN MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto heart failure</u> DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>and old age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. Month, Day, Year <u>1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3921 EDMONDSON AVE</u> 20f. (City or town) <u>BALTO.</u> (County) <u>MD.</u> (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>Oct. 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 3, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>H. W. SCHYE</u> 22c. PHYSICIAN'S NAME (Type) <u>H. W. SCHYE MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>OCT. 4, 61</u> 22d. ADDRESS <u>3921 EDMONDSON AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10/6/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PK. CEMT</u> 23d. LOCATION (City, town or county) <u>BALTO. MD.</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUN. DIR.</u> ADDRESS <u>4101 EDMONDSON AVE</u> 25a. REC'D BY REGISTRAR <u>OCT 6 '61</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



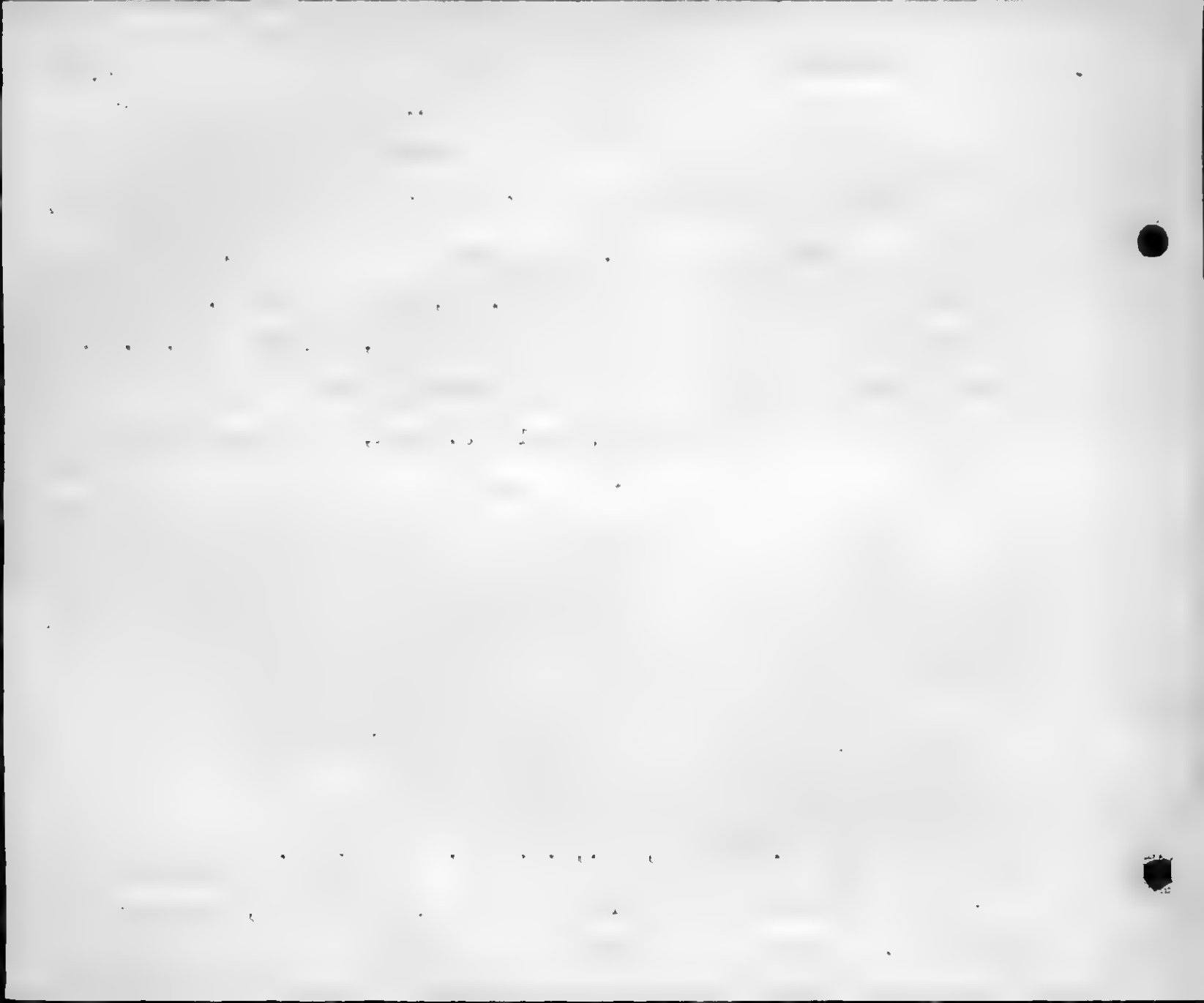
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11163

11153

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home				d. STREET ADDRESS 6108 Sunny Lane #7			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Edna		First Edna		Middle W.		Last Riggs	
4. DATE OF DEATH Month Oct. Day 19, Year 1961							
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Macgregor, Canada		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Watson				14. MOTHER'S MAIDEN NAME Margaret Lamb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 217-34-9077		17. INFORMANT Address Helen J. Burn, 6108 Sunny Lane #7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic cerebral vascular disease 331X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the) hospital attended the deceased from July 1953 to Oct. 19 , 1961, that (I) (we) last saw the deceased alive on Oct 17 , 1961, and that death occurred at 4:45 PM from the causes and on the date stated above.							
22a. SIGNATURE John A. Nesbitt Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) John A. Nesbitt, Jr., M.D.		22d. ADDRESS 4 S. Rolling Rd.					
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/20/61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR DATE OCT 23 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HEALTH OFFICIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

BP

MARYLAND STATE DEPARTMENT OF HEALTH

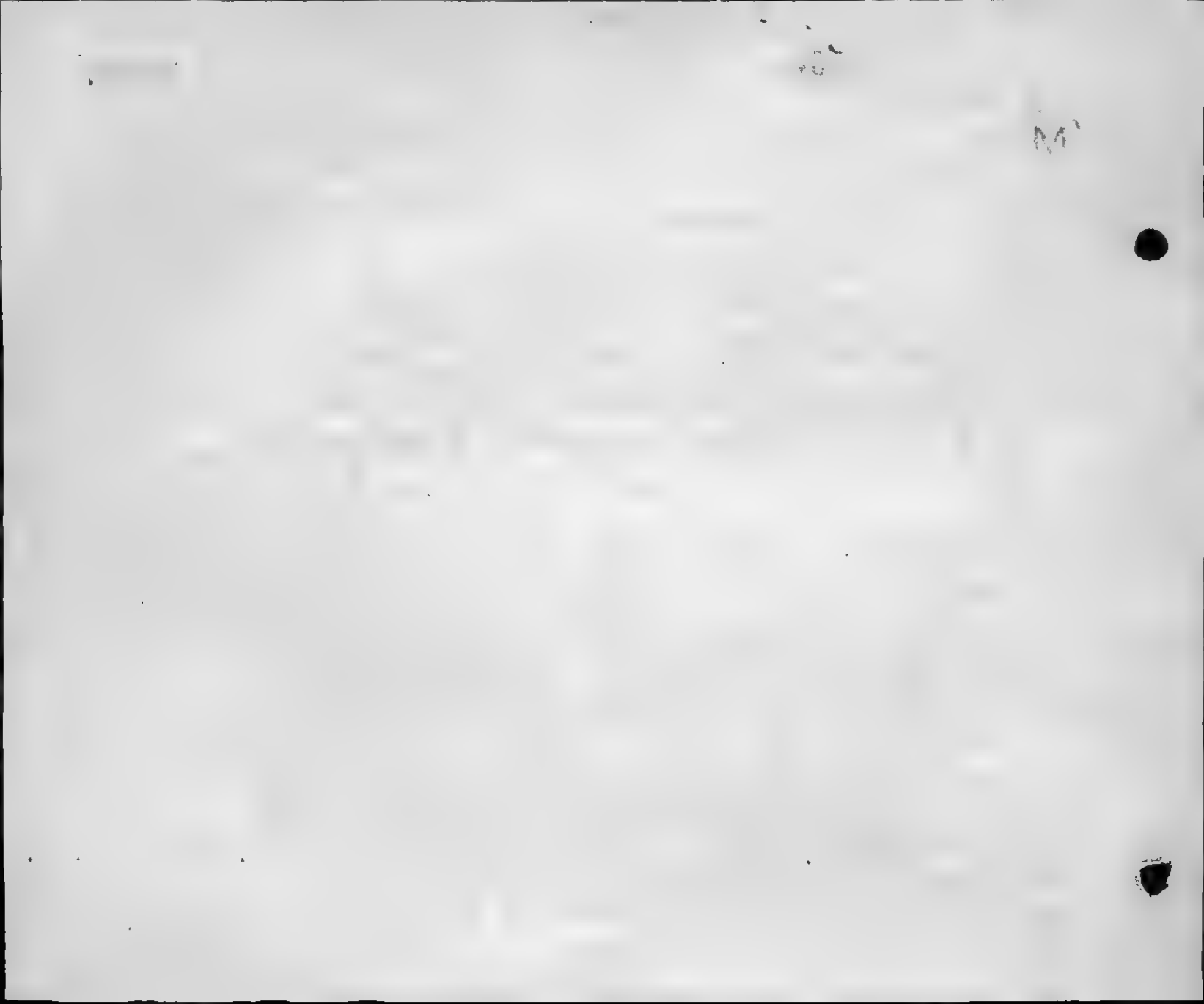
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11164

CERTIFICATE OF DEATH

11154

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> c. LENGTH OF STAY IN 1b <u>Arbutus</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>217 Oaklee Village</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>217 Oaklee Village</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN O. ROBINSON SR.</u> First Middle Last		4. DATE OF DEATH <u>Oct. 27 1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/94</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore Transit ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>67</u> Months Days Hours Min.
11. BIRTHPLACE (County & State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ephraim Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>213 10 3075</u>	
17. INFORMANT <u>John C. Robinson Jr.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1960</u> to <u>Oct. 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 15, 1961</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Emmett P. Davis</u> M.D.		22b. DATE SIGNED <u>10/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Emmett P. Davis</u>		22d. ADDRESS <u>1515 Washington Blvd. Baltimore 30, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/31/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City, town or county) (State) <u>Balt. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Smith & Son</u>		25. REC'D BY REGISTRAR <u>NOV 1 '61</u>	
ADDRESS <u>28</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
11165
11155
M
X
I

1
11165
11155

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2809 Garnet Rd.</i>		d. STREET ADDRESS <i>2809 Garnet Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Carroll Richard Roeder</i>		4. DATE OF DEATH Month <i>10</i> Day <i>5</i> Year <i>19 61</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <i>Married</i> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-23-1894</i>
9. AGE (in years last birthday) <i>67</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electrician</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph H. Roeder</i>		14. MOTHER'S MAIDEN NAME <i>Rosa Kathman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>213107462</i>		17. INFORMANT <i>Marian B. Roeder</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <i>Coronary occlusion</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Infected bursa, right elbow (healed)</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>11</i> p.m. <i>11</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 18, 1961</i> to <i>Oct 5, 1961</i> that (I) (we) last saw the deceased alive on <i>Sept 5, 1961</i> , and that death occurred at <i>5:15</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>G. M. Bacon</i>		22b. DATE SIGNED <i>10/6/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>		22d. ADDRESS <i>2810 Taylor Ave.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>10-9-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 9 '61</i>	
ADDRESS <i>5305 Hargord Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

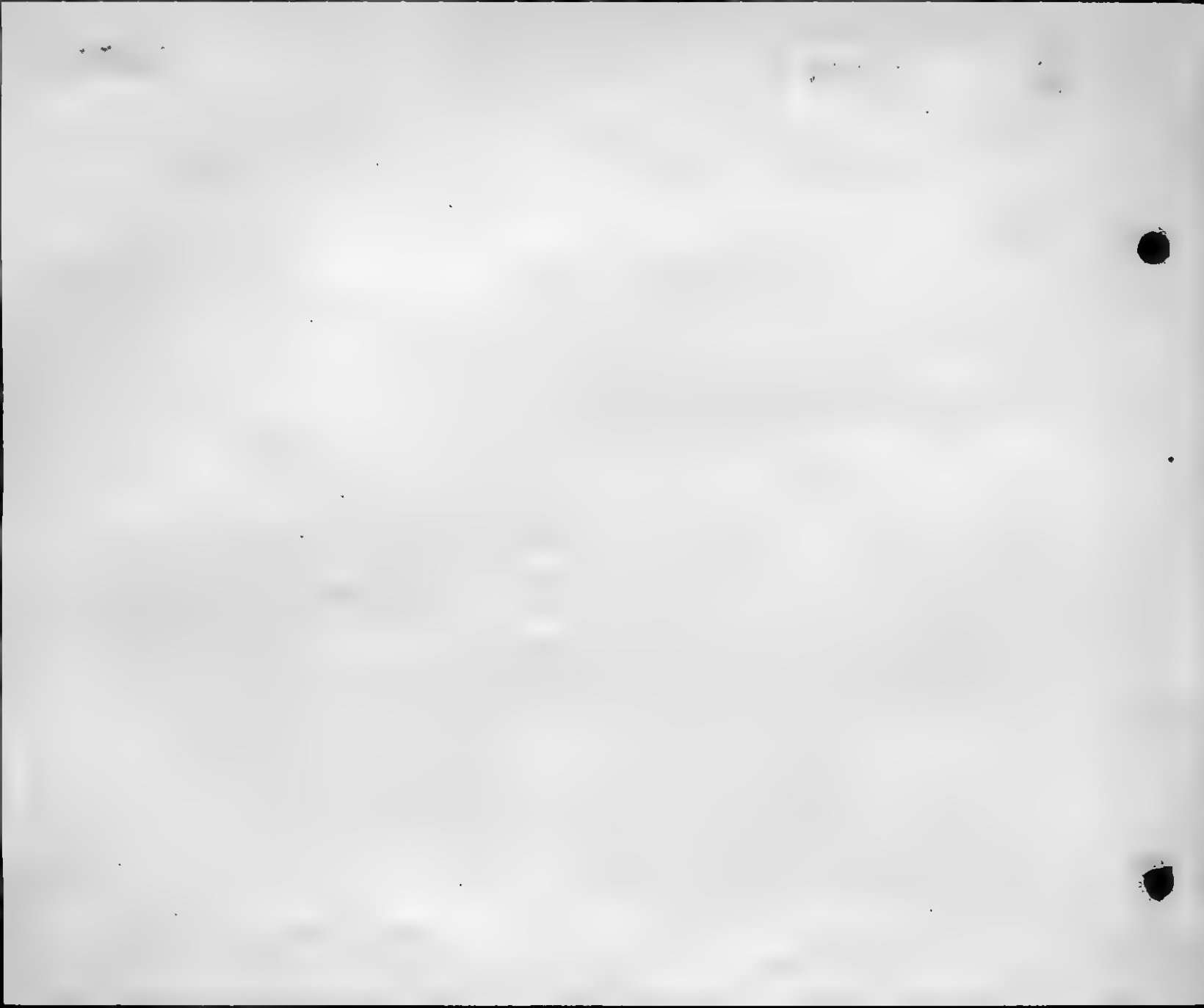


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
11166															
11156															
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>TOWSON CONVALESCENT HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>701 WASHINGTON AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>WILLIAM ARTHUR ROGERS</u>				4. DATE OF DEATH <u>OCTOBER 28 1961</u>				5. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Mins. <u> </u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 23, 1874</u>		9. AGE (In years last birthday) <u>87</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER - RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>WILLIAM HENRY ROGERS</u>				14. MOTHER'S MAIDEN NAME <u>?</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>FAMILY RECORDS</u>				Address <u> </u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) <u>442X</u> DUE TO <u>Decomposition</u> (b) <u>Arteriosclerotic Cardio-Renal</u> (c) <u>Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS <u> </u> (Enter conditions related to the terminal disease condition given in Part I.)				INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>10 yrs</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>April 1949</u> to <u>October 1961</u> , that (I) (we) last saw the deceased alive on <u>10/27 1961</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>10/28/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>				22d. ADDRESS <u>7501 York Rd - Towson, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>OCT. 31, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>		23d. LOCATION (City, town or county) <u>TOWSON, MD.</u> (State) <u> </u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burne Jones</u>				ADDRESS <u>Towson, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hanna</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11167

CERTIFICATE OF DEATH

11167

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN (b) <u>3 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>212 Parkwood Road</u>									
3. NAME OF DECEASED (Type or print) <u>WILLIAM T. RYAN</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>19 61</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>December 27, 1899</u>									
9. AGE (In years last birthday) <u>61</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Power House</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Samuel Ryan</u>									
14. MOTHER'S MAIDEN NAME <u>MN: Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>212-10-2184</u>									
17. INFORMANT <u>Clinical Records, VAH, Baltimore 18, Maryland</u> <u>Fort Howard Division</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BILATERAL TUBERCULOSIS, PULMONARY, WITH CAVITATION</u> <u>XXXX RIGHT LUNG AND TUBERCULOUS PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACTIVE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19 61</u> Hour a.m. <u>6:40</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		(County)		(State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 6, 1961</u> to <u>October 9, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 9, 1961</u> , and that death occurred at <u>AM</u> M., from the causes and on the date stated above.													
22a. SIGNATURE <u>Sebastian Russo</u>		22b. DATE SIGNED <u>10/9/61</u>		22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>									
22d. ADDRESS <u>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>									
23d. LOCATION (City, town or county) <u>Baltimore County, Maryland</u>		23e. (State)											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>									

Md.

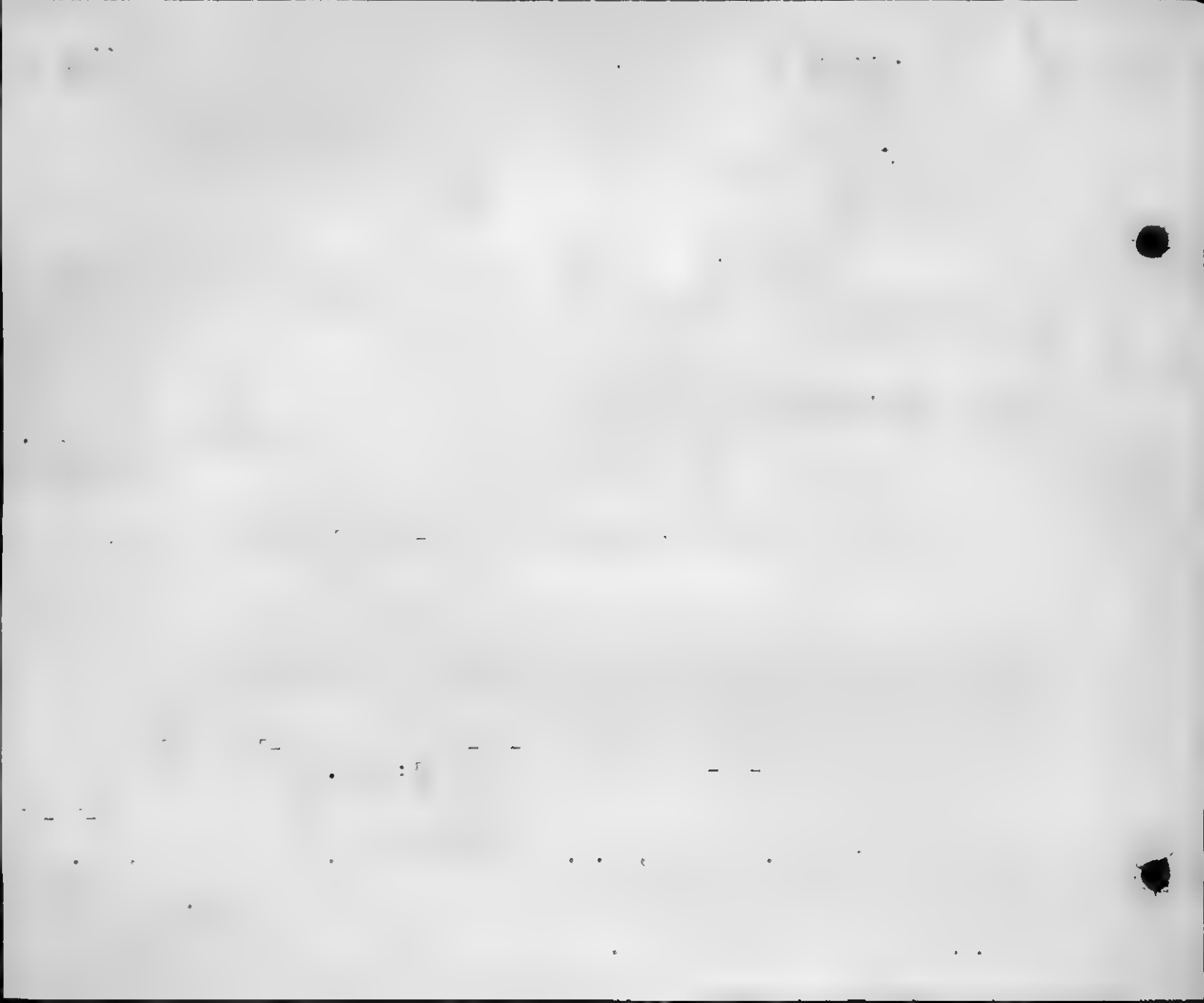
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11168					11158				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Baltimore</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>Kemp Road</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kemp Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <u>Henry A. Schaefer</u>					Month Day Year <u>October 12, 1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 16, 1876</u>		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>Henry C. Schaefer</u>					14. MOTHER'S MAIDEN NAME <u>Annie Walters</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>217-36-4089</u>				
					17. INFORMANT <u>John Edward Schaefer, Kemp Road, Reisterstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> (c) <u>years</u> DUE TO (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6-20-49</u> , 19 <u>61</u> , to <u>10-12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-12-1961</u> , and that death occurred <u>11:30 P.M.</u> on the causes and on the date stated above.									
22a. SIGNATURE <u>Martin E. Strobel</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-13-61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>					22d. ADDRESS <u>48 Main St. Reisterstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 15, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>All-Saints Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Reisterstown, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Fline & Sons, Reisterstown, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fline</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11169											
11159											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville-Paradise & Altamont</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paradise Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>767 Grantley Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Blanche R. Schmoll</u> First Middle Last 4. DATE OF DEATH <u>Oct. 26 19 61</u> Month Day Year						9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 28, 1884</u>						10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					
10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					
13. FATHER'S NAME <u>William R. Roberts</u>						14. MOTHER'S MAIDEN NAME <u>? Evans</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Katherine Newman-1230 Stevens Avenue</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>4+2</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> Month, Day, Year						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>2-11-53</u> , 19....., to <u>10-26-61</u> , that (I) (we) last saw the deceased alive on <u>10-24-61</u> , 19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Harry S. Gumbel</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/26/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>HARRY S. GUMBEL</u>						22d. ADDRESS <u>4605 Edmonson Ave</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>10-28-61</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>						23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Jackson & Sons</u> ADDRESS <u>Balto. 17, 7nd.</u>						25a. REC'D BY REGISTRAR <u>OCT 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Haines</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11160

1
FOR STATE
HEALTH DEPT.
(M)
TO DUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
(I)

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
c. LENGTH OF STAY IN 1b <u>3 yrs</u>				d. STREET ADDRESS <u>35 Kinship Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>35 Kinship Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph E. Schuttz</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 30 - 07</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Smelter</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Schuttz</u>				14. MOTHER'S MAIDEN NAME <u>Anna Zakor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>42-07-8555</u>			
17. INFORMANT <u>Joseph L Schuttz</u>				Address <u>1804 Darrich Dr. (14)</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>10/14/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR <u>Geppel Bros 1500 F. Howard St.</u>				24a. REC'D BY REGISTRAR <u>10/16/61</u>			
				24b. REGISTRAR'S SIGNATURE <u>S. Harris</u>			

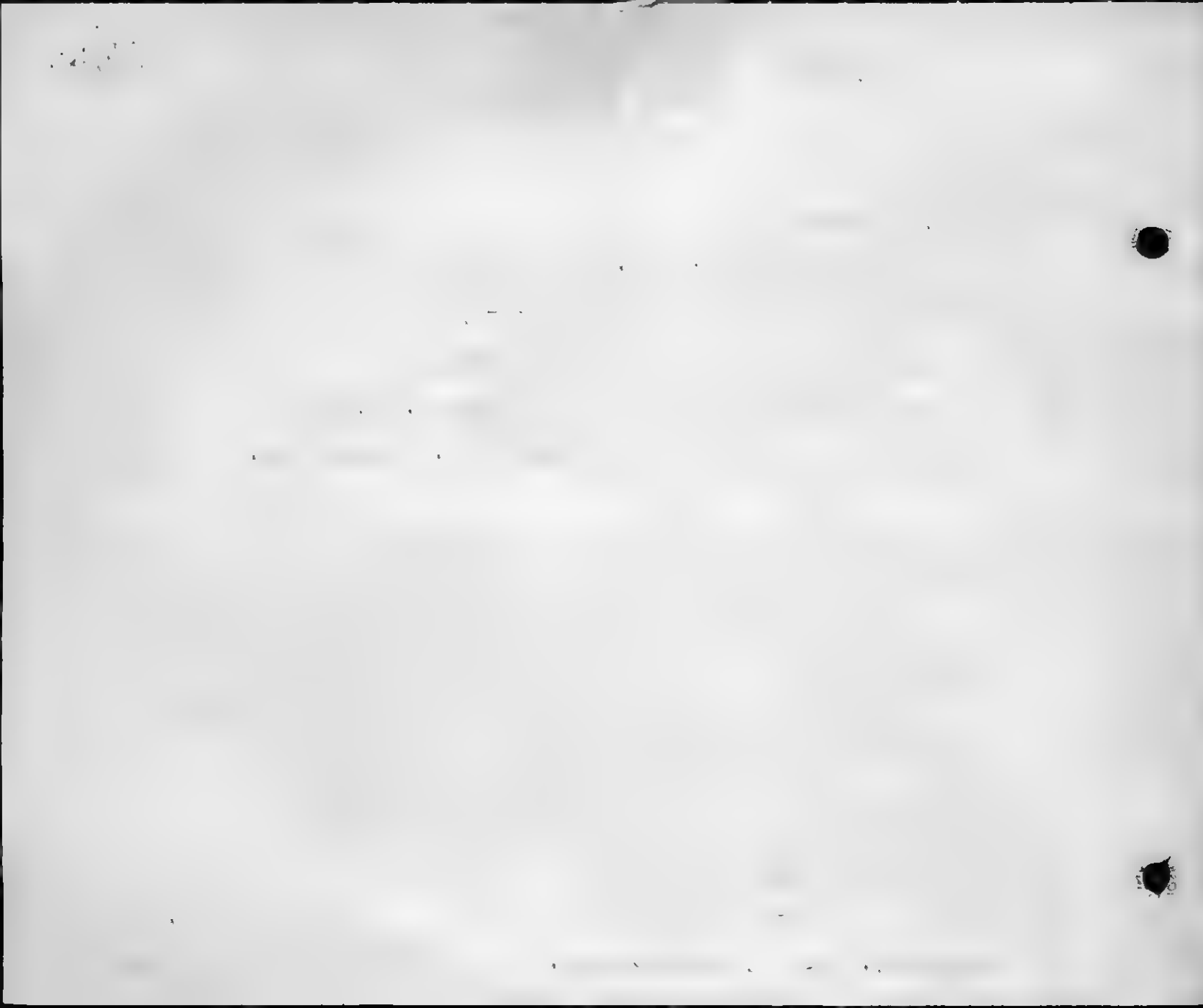


TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11171
11161
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7912 Beverly Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>7912 Beverly Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mildred G. Scotney</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-6-1913</u> 9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>		4. DATE OF DEATH <u>October 25, 1961</u> 10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Schultz</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>214201744</u> 16. SOCIAL SECURITY NO. <u>Herbert M. Scotney, Jr.</u> 17. INFORMANT <u>same</u> Address <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>171X</u> DUE TO <u>Uterine Obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Carcinoma of the Cervix (IC. 4)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Vesicovaginal fistula post irradiation</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>3 mos</u> <u>JAN 61</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <u>Jan 1961</u> to <u>Oct 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>10/12/61</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>John Hupewell Hebb</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>JOHN HUPEWELL HEBB</u> 22d. ADDRESS <u>701 CATHOLIC PL BALD 12 MD</u> 22b. DATE SIGNED <u>10/25/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>10-28-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Hartford Rd.</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hanna</u> DATE <u>OCT 27 '61</u>	

10/27/61



CERTIFICATE OF DEATH

Reg. Dist. No.

11162

11172

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home in the Pines Nursing & Convalescent Home</u>				d. STREET ADDRESS <u>1442 Haubert ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MATHIAS</u> Middle <u>SEIF</u> Last <u>SEIF</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>25</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-1891</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mathias Seif</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-0620</u>		17. INFORMANT <u>Mrs. Anna Seif</u> Address <u>1442 Haubert ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? <u> </u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>9/22, 1961</u> , to <u>10/25, 1961</u> , that I last saw the deceased alive on <u>10/18, 1961</u> , and that death occurred at <u>5:00</u> P.M. from the causes and on the date stated above. ADDRESS [Street, city or town, state] DATE SIGNED							
ACTUAL SIGNATURE <u>E. S. FLLISON</u> M.D.				PHYSICIAN'S NAME (Type) <u>E. S. FLLISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-30-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Stevens</u> <u>Funeral Home, Inc.</u>				ADDRESS <u>1501 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>NOV 1 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

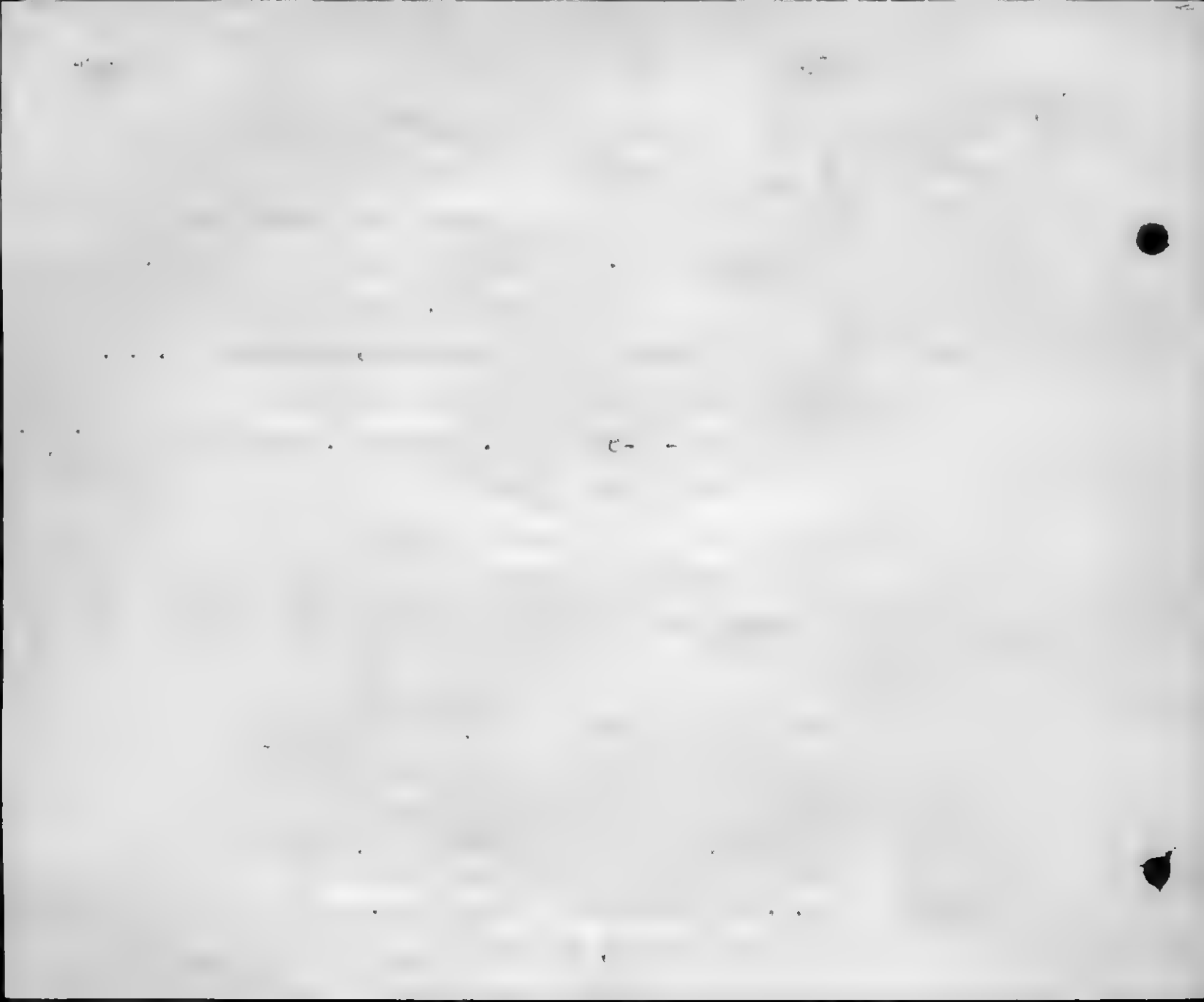
11173

CERTIFICATE OF DEATH

11163

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 16 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 11220 Reisterstown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Richard Middle A. Last Smith		4. DATE OF DEATH Month October Day 3 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1904		9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY Bakery				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Richard Smith						14. MOTHER'S MAIDEN NAME Mary Ann Durham											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II						16. SOCIAL SECURITY NO. 212-07-8792						17. INFORMANT Mrs. Richard A. Smith Address 11220 Reis. Rd. Owings Mills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (b) Secondary to Pulmonary Fibrosis (c) Pulmonary Tuberculosis stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 6 mos. 2 yrs. 2 yr. 9mo.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Renal Insufficiency														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Hour _____ e.m. _____ p.m. _____ none				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				20f. (City or town) 1-5-50		(County) 10-3-61		(State)			
21. I certify that (I) (this hospital) attended the deceased from 1-5-50 , 19 , to 10-3-61 , 19 , that (I) (we) last saw the deceased alive on 10-2-61 , 19 , and that death occurred at 2A M, from the causes and on the date stated above.																	
22a. SIGNATURE D. D. Caples M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-4-61			
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.												22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 6, 1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.				23d. LOCATION (City, town or county) Baltimore, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Henry James Ellkluft												ADDRESS Owings Mills, Maryland		25a. REC'D BY REGISTRAR Oct 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9.60

MEDICAL CERTIFICATION

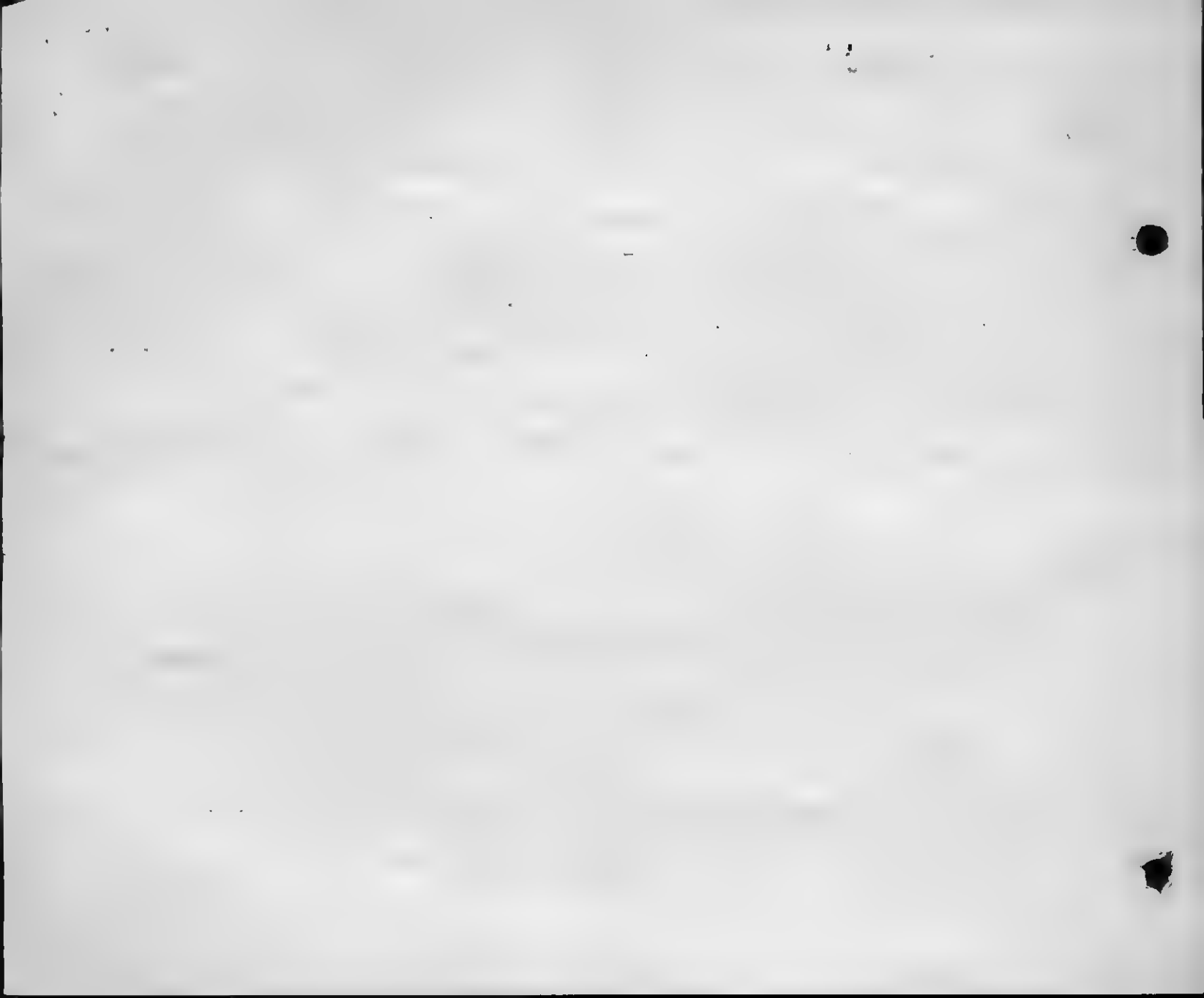
11-15-61 film 300
11-15-61
11-15-61 film 300
11-15-61 film 300

11174
11-15-61 film 300
11-15-61 film 300
11-15-61 film 300

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2511 Yorkway

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk
d. STREET ADDRESS 2511 Yorkway a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) CHARLES STEPHENS
4. DATE OF DEATH October 31 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Jan. 21, 1938
9. AGE (In years last birthday) 23 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lin Mill 10b. KIND OF BUSINESS OR INDUSTRY Beck Steel 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles W. Stephens 14. MOTHER'S M.A.D.E.N NAME Amelia Goldbaum
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Ellen Stephens 2511 Yorkway 17. INFORMANT Ellen Stephens 2511 Yorkway
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 936.0 DUE TO Undetermined - Drowning or electrocution
Conditions, if any, which gave rise to immediate cause (b) 936.0 DUE TO Undetermined - Drowning or electrocution
(a), stating the underlying cause last. (c) Undetermined - Drowning or electrocution
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Undetermined - Drowning or electrocution
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in bathtub full of water with radio submerged in tub
20c. TIME OF INJURY Month, Day, Year 7:30 AM 10-31-61 20d. INJURY OCCURRED Home Dundalk Balto. Md.
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Dundalk (County) Balto. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒
CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒ 10-31-61 DATE SIGNED
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county) Howard G. Shaub, M. D.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Nov 3/61 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem 22d. LOCATION (City, town, or country) Baltimore County (State) Md.
23. FUNERAL DIRECTOR William L. Linn ADDRESS 2112 Dundalk 24a. REC'D BY REGISTRAR NOV 14 '61 24b. REGISTRAR'S SIGNATURE Charles L. Hines



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

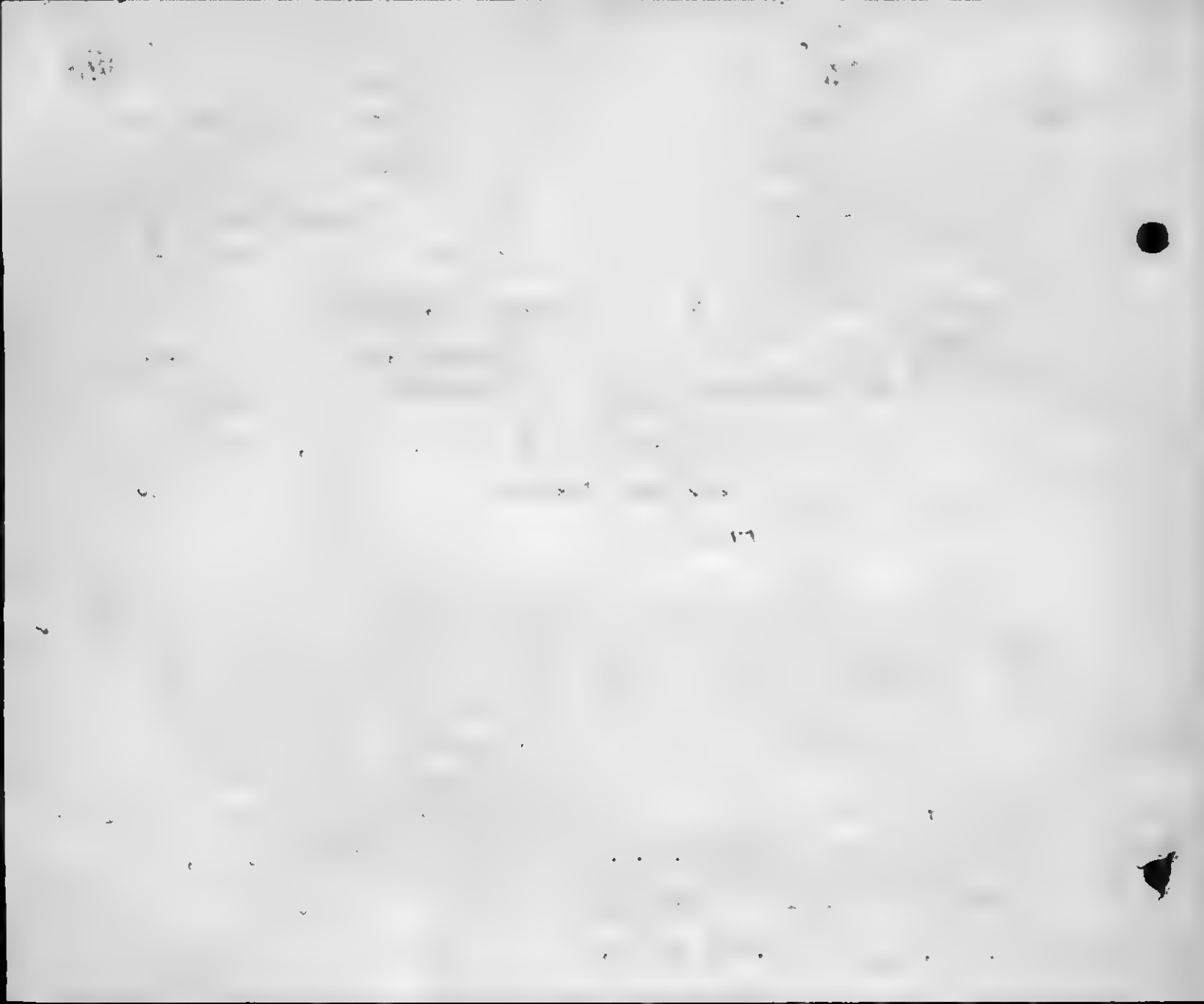
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11175

11164

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 27 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1212 Poplar Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 27 d. STREET ADDRESS 1212 Poplar Avenue	
3. NAME OF DECEASED (Type or print) Alice		4. DATE OF DEATH October 18 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Whitworth		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-22-6852	
17. INFORMANT Richard F. Stoetzer, 1212 Poplar Ave		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) HTA SCVD CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-6-56 to 10-24-61 , 19..., that (I) (we) last saw the deceased alive on 10-23-61 , 19..., and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Nathan Racusin		22b. DATE SIGNED 10-20-60	
22c. PHYSICIAN'S NAME (Type) Nathan Racusin, M.D.		22d. ADDRESS 206 South Gilmore Street, ZONE 23	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-23-61	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City, town or county) (State) Baltimore
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2		25a. REC'D BY REGISTRAR OCT 24 '61	
25b. REGISTRAR'S SIGNATURE Wm. S. Thomas			

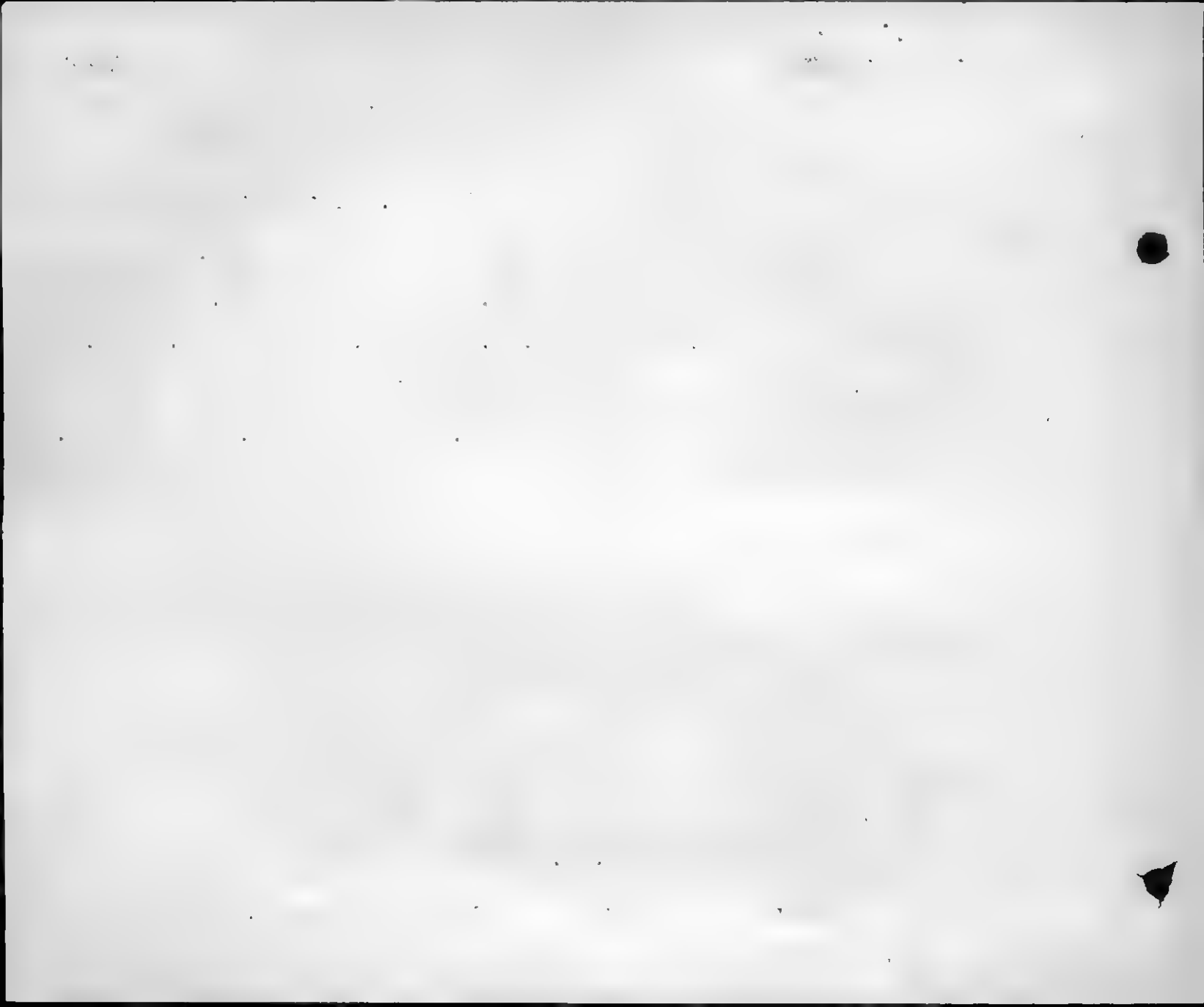


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9-59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1005 St. Charles Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Edward Last Storm		4. DATE OF DEATH Month Oct. Day 3, Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1900
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) supervisor		10b. KIND OF BUSINESS OR INDUSTRY General Elect. Co.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Storm		14. MOTHER'S MAIDEN NAME Catherine Shriner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-09 8793	
17. INFORMANT Ruth M. Storm		Address 1005 St. Charles Ave. #29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 16231 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 1, 1961 , to October 3, 1961 , that (I) (we) lost the deceased alive on October 2, 1961 , and that death occurred at 3A M, from the causes and on the date stated above.			
22a. SIGNATURE Morris Steinberg		22b. DATE SIGNED 10/4/61	
22c. PHYSICIAN'S NAME (Type) Morris Steinberg, M. D.		22d. ADDRESS 333 3913 Hollins Ferry Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR Oct 5 '61	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Charles E. Frank	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

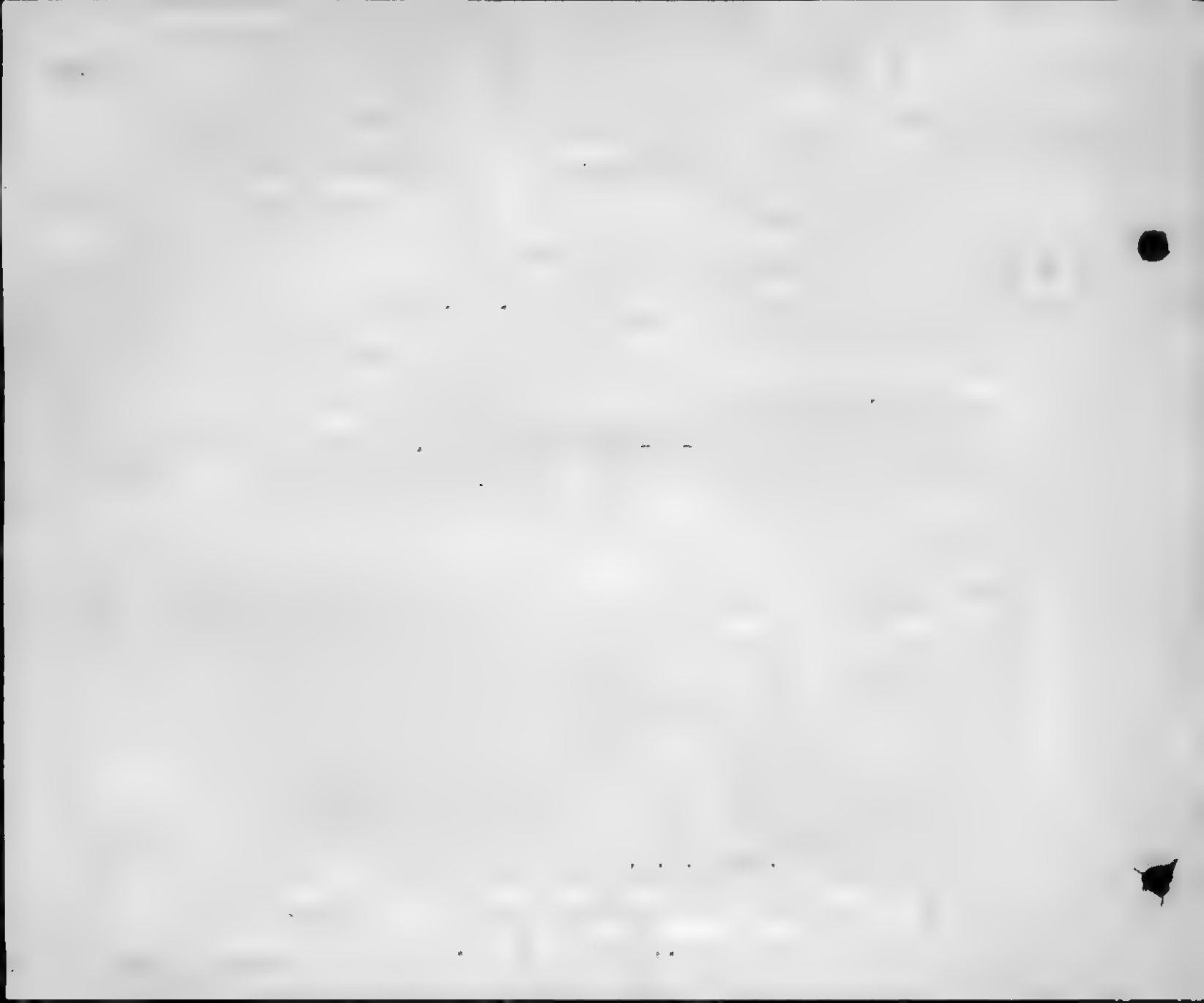
11177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11166

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22) c. LENGTH OF STAY IN b 24 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 129 Ventnor Terrace		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22) d. STREET ADDRESS 129 Ventnor Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERNARD VIRGIL STRADTNER 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 7th, 1902 9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR: Months 5 Days 10 Hours 10 Min. 10		4. DATE OF DEATH October 10th, 19 61 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder 10b. KIND OF BUSINESS OR INDUSTRY Steel 11. BIRTHPLACE (State or foreign country) Indiana 12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John C. Stradtner 14. MOTHER'S MAIDEN NAME Alma Cobble 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 213-09-1819 17. INFORMANT Florence O. Stradtner Address same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO Coronary Occlusion (a), stating the underlying cause last. (c) 420.1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year 19 61 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Dundalk (County) Baltimore (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis, M.D. EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/11/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/13/61 22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial 22d. LOCATION (City, town, or country) Dorsey, Maryland		23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md. 24a. REC'D BY REGISTRAR Oct 13 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Fennell	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

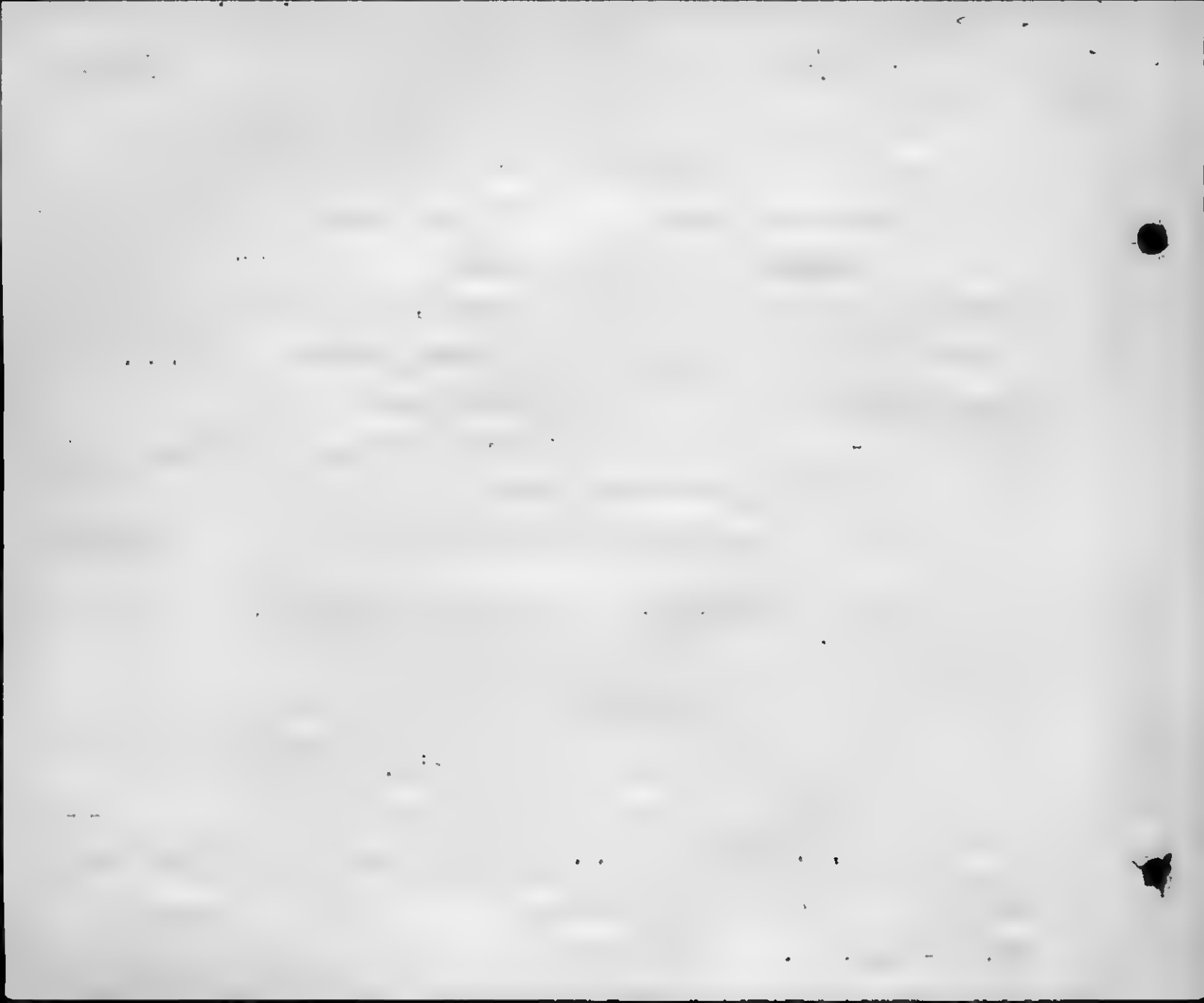
11178

11167

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY in 1b <u>116 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>204 Poplar Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>CARLYN M. STUART</u> First Last Middle 5. SEX <u>FEMALE</u> 6. COLOR <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>October 1 1961</u> Month Day Year 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Wittich</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW-1</u> 16. SOCIAL SECURITY NO. <u>WW-1</u> 17. INFORMANT <u>Clin Rec VAH Baltimore Md Ft Howard Division</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>411X CALCIFIC AORTIC STENOSIS</u> DUE TO (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hypertensive Vascular Disease; Arteriosclerotic Heart Disease; Diverticulosis.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 7 1961 to Oct 1 1961</u> that <u>no</u> (we) last saw the deceased alive on <u>Oct 1 1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. M. SNYDER</u> 22c. PHYSICIAN'S NAME (Type) <u>C. M. SNYDER</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u> 22b. DATE SIGNED <u>10-1-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u> 25b. REGISTRAR'S SIGNATURE <u>DATE OCT 10 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

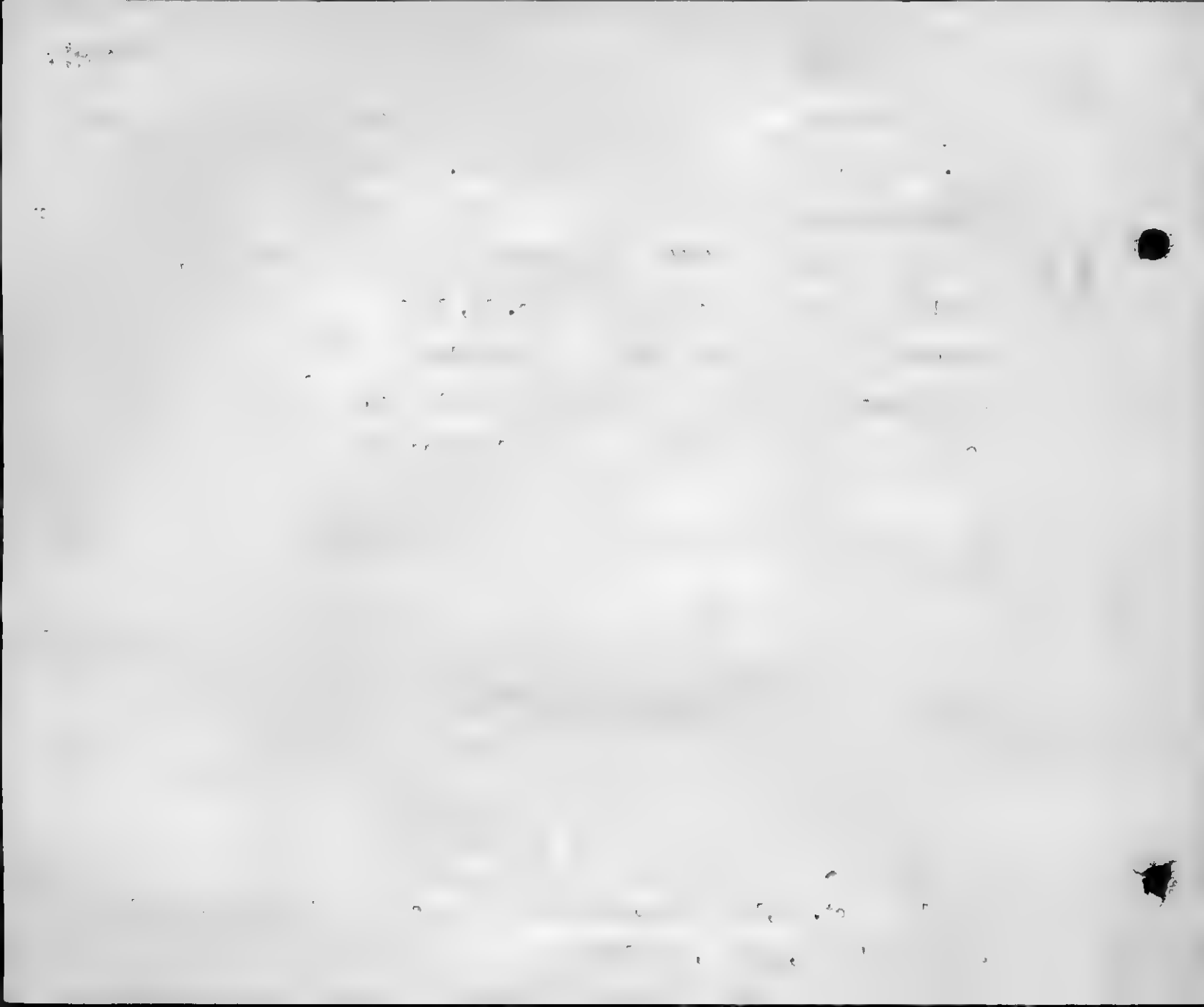


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11179 Item 8 Film 0297 10/21/61 mh											
11168											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1218 Lake Avenue				e. STREET ADDRESS 1218 Lake Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNIE FISHPAW Fishpaw STULLER				4. DATE OF DEATH Month October Day 15 Year 1961							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1878		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME John Fishpaw				14. MOTHER'S MAIDEN NAME Sally King				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Family Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) And Sclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m.											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Oct 25, 1960 to Oct 15th, 1961 , that (I) (we) last saw the deceased alive on Sept 20th, 1961 , and that death occurred at 2:30 p.m. from the causes and on the date stated above.											
22a. SIGNATURE James A. Miller M.D.											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) James A. Miller M.D.											
22d. ADDRESS 1331 Reisterstown Rd. Pikesville - Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF Oct. 18, 1961											
23c. NAME OF CEMETERY OR CREMATORY Jesseps Methodist Cemetery											
23d. LOCATION (City, town or county) (State) Cockeysville, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland											
25a. REC'D BY REGISTRAR DATE OCT 19 '61											
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna											



CERTIFICATE OF DEATH

Reg. Dist. No. 11169

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Donnalh</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>731 S. Avondale Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Donnalh 22, Md.</u>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Landonia Reed SWANN</u>		4. DATE OF DEATH Month Day Year <u>October 25, 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20-1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worked on Farm</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	11. BIRTHPLACE (State or foreign country) <u>Farmville, Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Sallie Swann 731 S. Avondale Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC Heart Disease</u> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1954</u> to <u>October 25, 1961</u> that I last saw the deceased alive on <u>October 25, 1961</u> and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u>		ADDRESS (Street, city or town, state) <u>140 Oak Ave.</u> DATE SIGNED <u>10/25/61</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade</u>		<u>Donnalh 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-29-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles R. Law 802 Madison Ave., Balto., 1, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



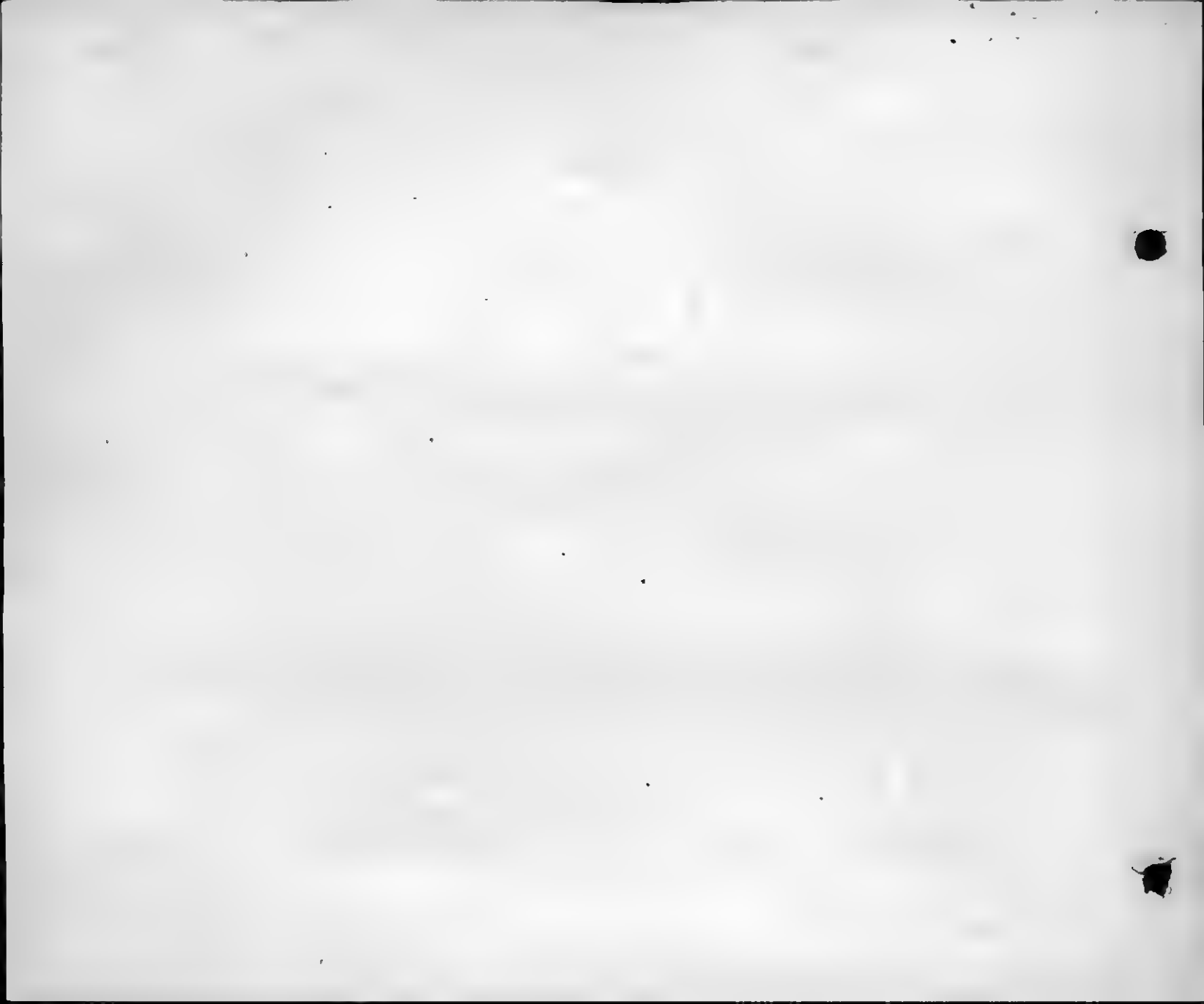
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

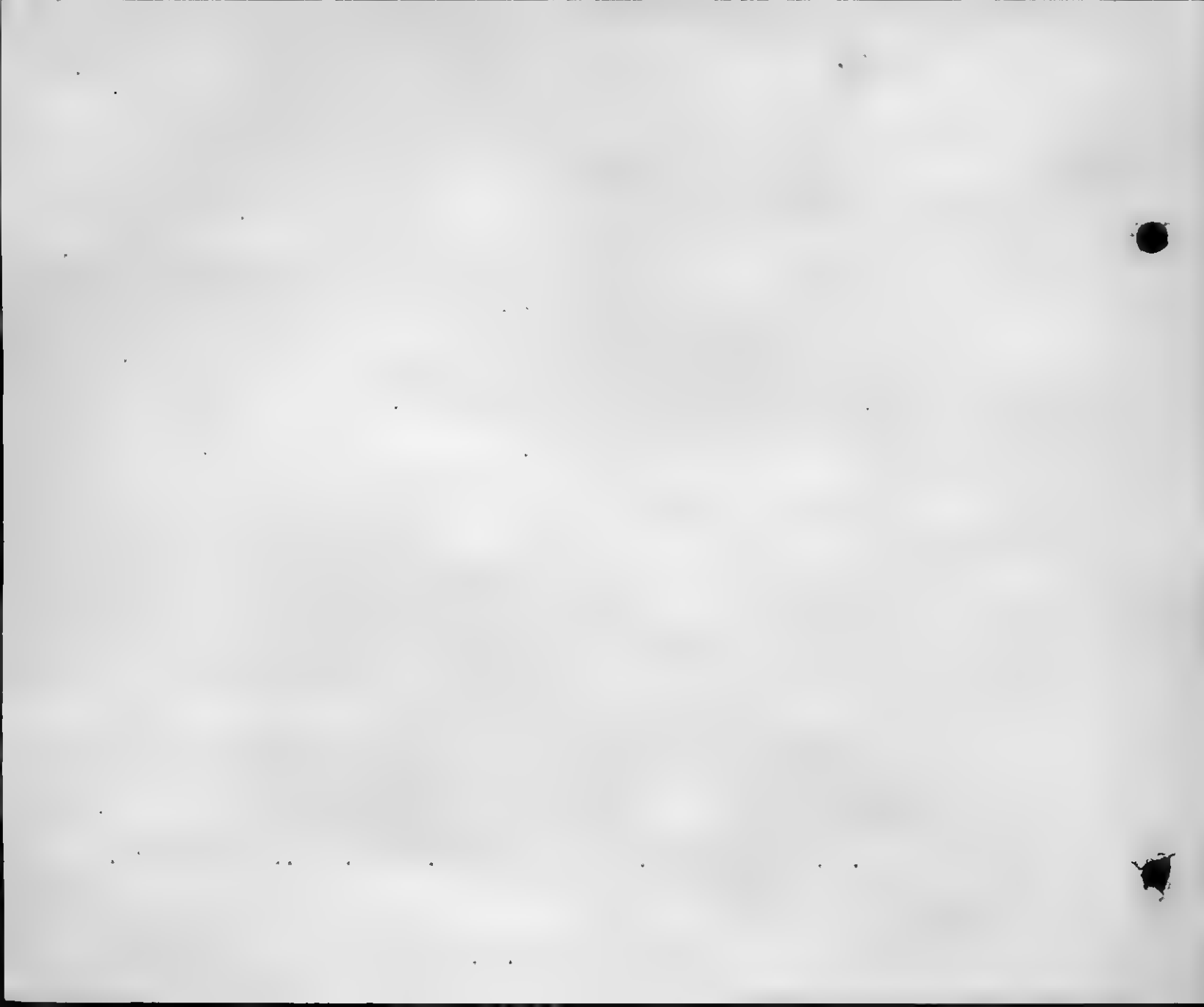
VR A15 (4)
15M 9/59

1
11181
M
X
W
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11170

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY in 1b 2 years XXXXXX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4506 Poplar Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LYDIA W TAYLOR First Middle Last		4. DATE OF DEATH Oct. 1, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1881
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? Canada	
13. FATHER'S NAME Isaac Springstead		14. MOTHER'S MAIDEN NAME Catherine McIntosh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT William W. Taylor, 4506 Poplar Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 154X DUE TO (inoperable) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardio Vascular disease DUE TO Senility (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 14 yr 6 mo. 5-7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1961 to Oct 1961 , that (I) (we) last saw the deceased alive on Sept 30 1961 , and that death occurred at 6:25 M. from the causes and on the date stated above			
22a. SIGNATURE B B Brumbach M.D.		22b. DATE SIGNED 10/2/61	
22c. PHYSICIAN'S NAME (Type) B B Brumbach		22d. ADDRESS 5609 main st Albany NY	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/61	
23c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery		23d. LOCATION (City, town, or county) (State) Hamilton, Ontario, Canada	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave,		25a. REC'D BY REGISTRAR DATE OCT 3 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

tem 20 Film 299
11-6-61 ams

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

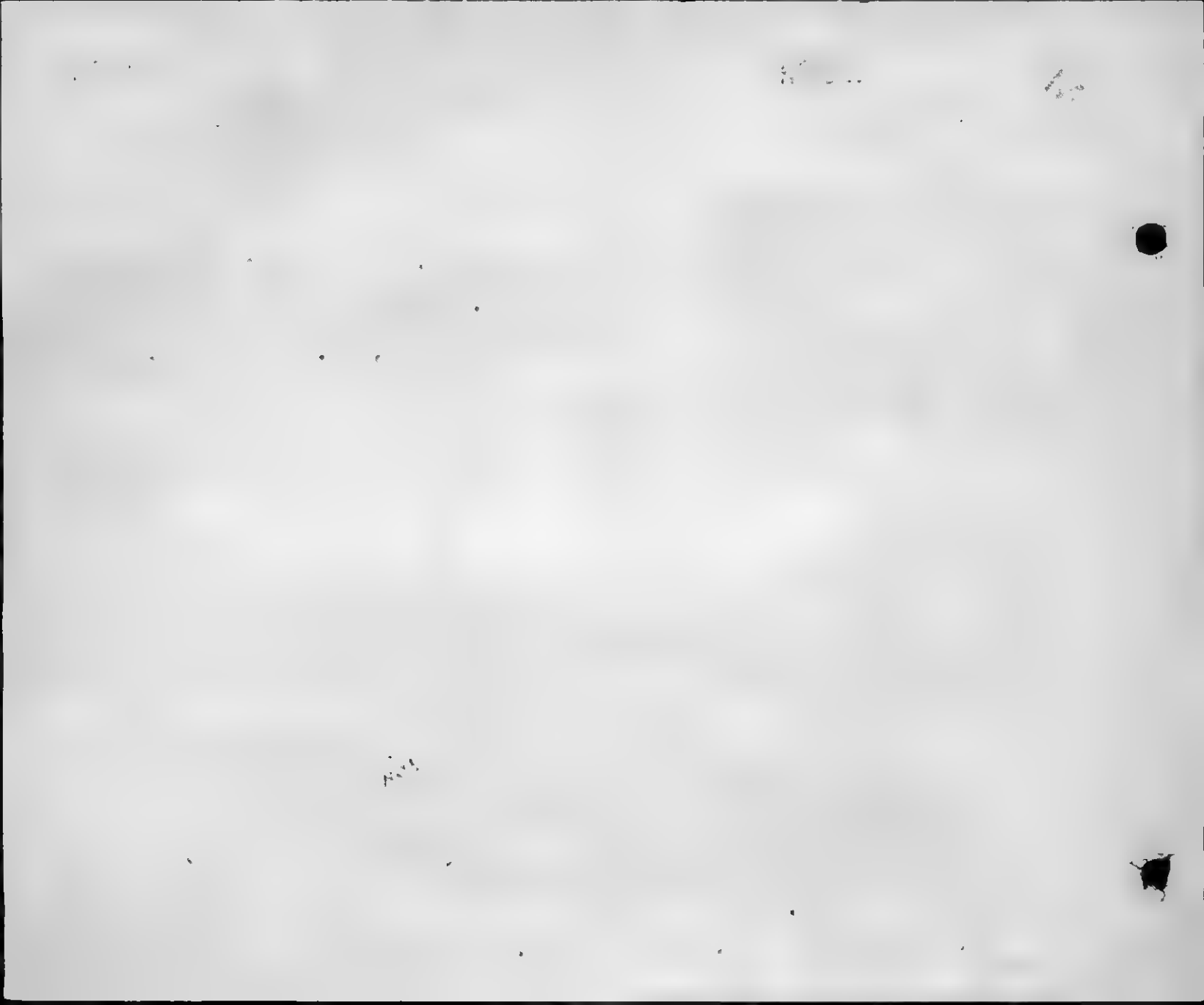
CERTIFICATE OF DEATH

11183

11172

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN <u>MD</u> <u>Baltimore</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1106 Longbrook Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1106 Longbrook Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(BABY) FRANK CARLISLE TISCH, JR.</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY		4. DATE OF DEATH <u>Oct. 30 1961</u> 9. AGE (in years last birthday) <u>1 4</u> 11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>Frank Carlisle Tisch</u> 14. MOTHER'S MAIDEN NAME <u>Judith Stanley</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>Frank C. Tisch, 1106 Longbrook Rd.</u> 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause, a line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>724.9</u> DUE TO <u>Suffocation</u> Conditions, if any, which gave rise to immediate cause (b) <u>Child was on abdomen and worked its face into plastic bunting which cut off the air</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>Sept. 26 1961</u> to <u>Oct. 30 1961</u>, that (I) (we) last saw the deceased alive on <u>Oct. 30 1961</u>, and that death occurred at <u>9:45 AM</u>, from the causes and on the date stated above.			
22a. SIGNATURE <u>Laurence C. Tisch</u> 22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. Tisch</u>		22b. ADDRESS <u>6805 York Rd. - Baltimore Md</u> 22d. DATE SIGNED <u>10/31/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>Oct. 31/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.</u> ADDRESS <u>1050 York Rd. 4</u> 25a. REC'D BY REGISTRAR <u>NOV 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

2047253XV4



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11184

11173

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11 S. Belle Grove Road</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
3. NAME OF DECEASED (Type or print) <u>Ethel</u> <u>Turner</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>October 26, 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of Instructing Visiting Nurses Assoc.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Liverpool, England</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William George Turner</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Haynes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>312-32-4913</u>			
17. INFORMANT <u>Mrs. R. Dorsey Watkins</u>				Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral metastases, Carcinoma of breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1948</u> , 19 <u> </u> to <u>Oct 7</u> , 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Oct 7</u> , 19 <u>61</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John A. Nesbitt</u>				22d. ADDRESS <u>1118 St. Paul St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Orleans</u>		23d. LOCATION (City, town or county) (State) <u>Orleans, Cape Cod, Mass.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc.</u>				ADDRESS <u>1900 Eutaw</u>		25a. REC'D BY REGISTRAR <u>PJ. OCT 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11185

Reg. Dist. No:

11174

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 33 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6903 Holabird Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)	
3. NAME OF DECEASED (Type or print) Katherine M. Uphoff		4. DATE OF DEATH Month October Day 18th Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Kirschenhofer		14. MOTHER'S MAIDEN NAME Mary Reinhardt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William Uphoff		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 10-18-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/61	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md		ADDRESS ONE 20' 61	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11186

CERTIFICATE OF DEATH

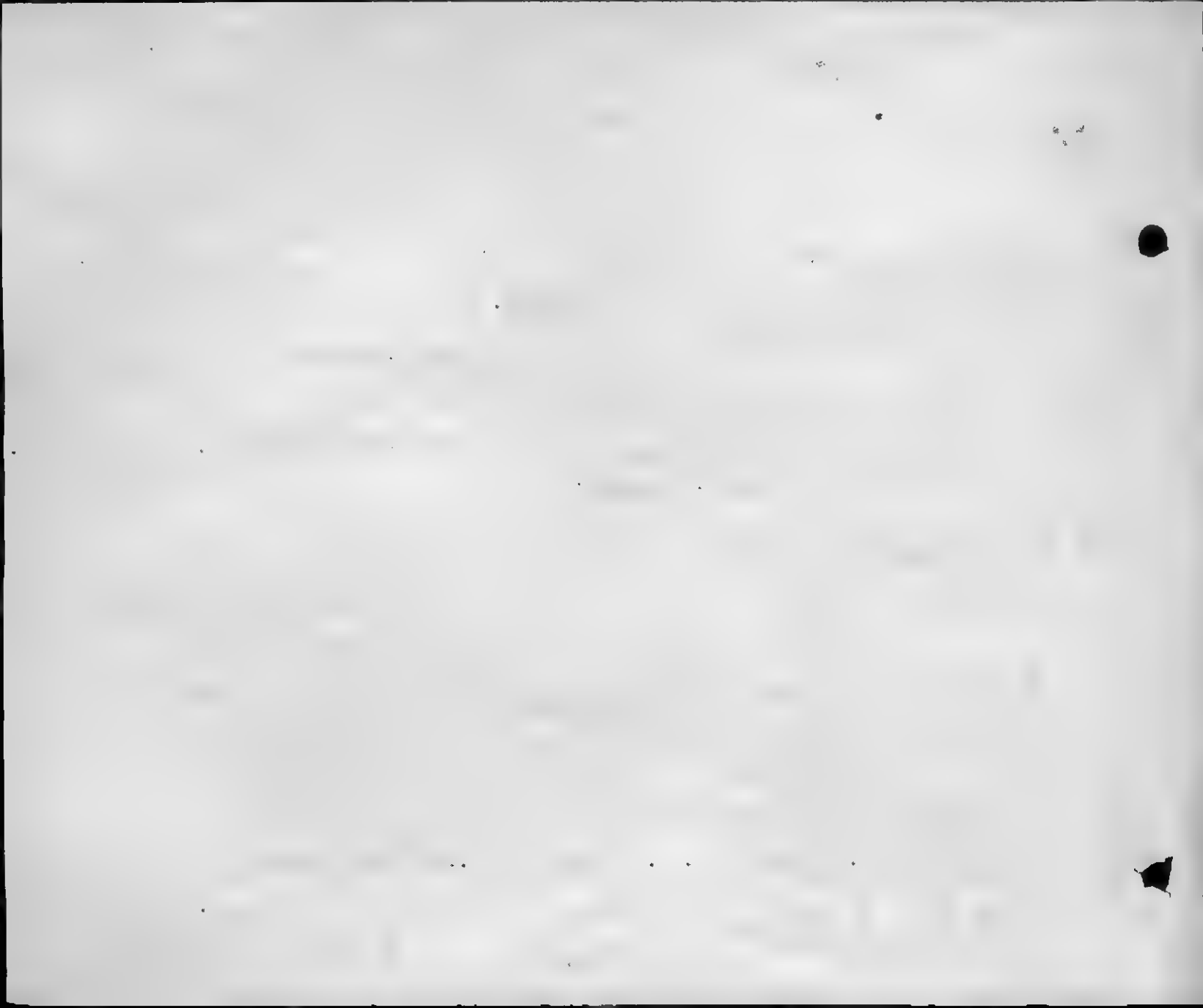
Reg. Dist. No. 11175

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7615 Eastern Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle CAROLINE Last VANDERMAST		4. DATE OF DEATH Month October Day 21 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. White		14. MOTHER'S MAIDEN NAME Maria L. Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Marie Connor		Address 501 Fairview Ave. Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 3 weeks 15 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/20/57 , 19____, to 10/24/61 , 19____, that I last saw the deceased alive on 10/20/61 , 19____, and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7422 EASTERN AVE Baltimore 24 Maryland. DATE SIGNED 10/23/61			
ACTUAL SIGNATURE Max Baumann		M.D. 7422 EASTERN AVE	
PHYSICIAN'S NAME (Type) MAX BAUM		Baltimore 24 Maryland.	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-61	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		ADDRESS 6224 Eastern Ave. MD.	
24a. REC'D BY REGISTRAR DATE OCT 26 '61		24b. REGISTRAR'S SIGNATURE Charles S. Geiler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1 FOR STATE HEALTH DEPT.

TO JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

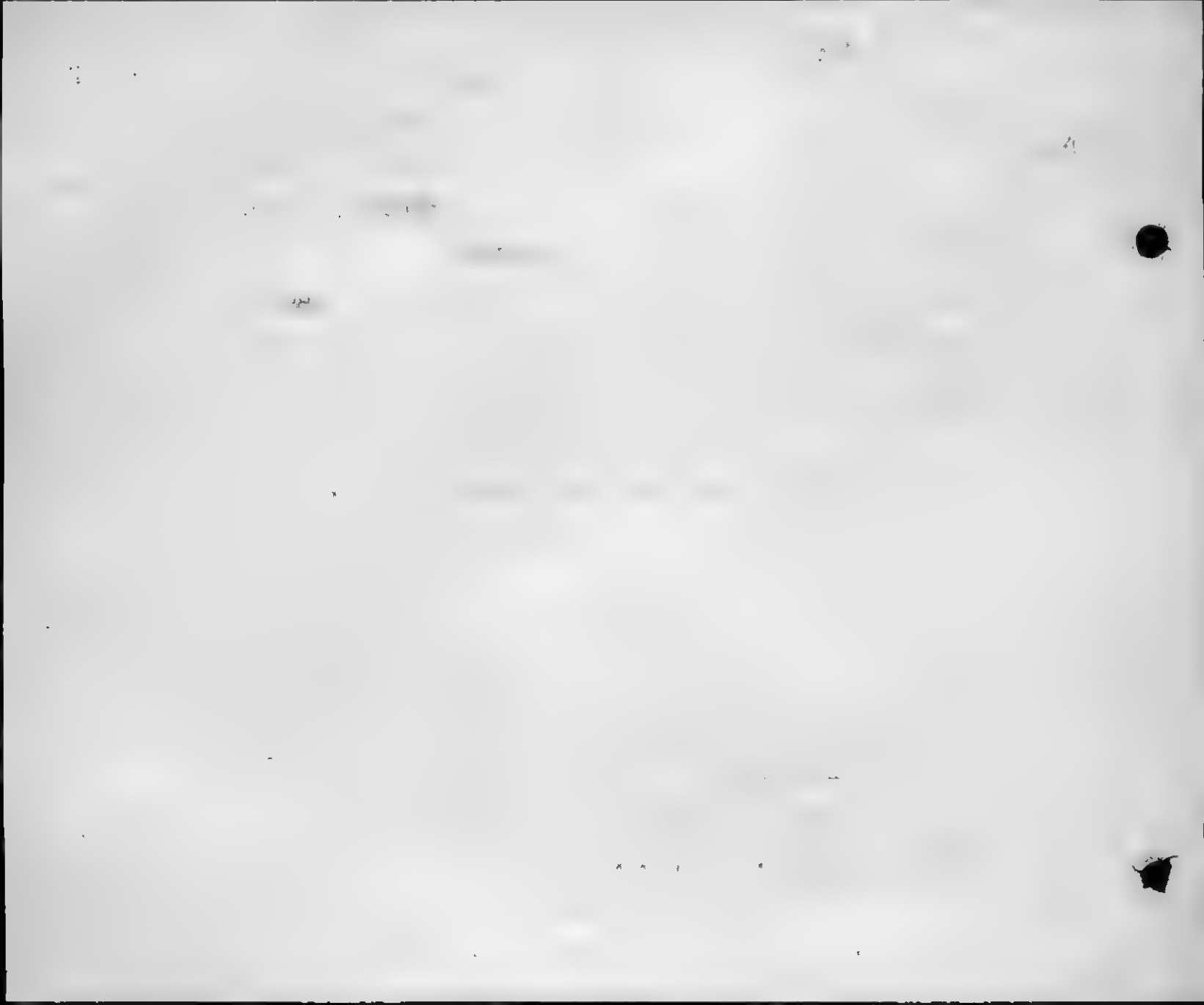
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11188

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11177

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 209 Westshire Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY ✓		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 606 Biddle Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) LILLIAN		First		Middle		Last		4. DATE OF DEATH Month October Day 28 Year 19 61		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 15, 02 59		9. AGE (In years last birthday) Months 59 Days 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Rodger Brooks		14. MOTHER'S MAIDEN NAME Lillian Sides		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-30-6100		17. INFORMANT Alfred Coleman		Address 3107 Philips Lane		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease. 443 X DUE TO Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1961		22c. NAME OF CEMETERY OR CREMATORY West Chapel Cemetery		22d. LOCATION (City, town, or country) Westminister, Maryland		23. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1808 W. Monroe St.		24a. REC'D BY REGISTRAR DATE NOV 1 '61		24b. REGISTRAR'S SIGNATURE Charles S. Petty		DATE SIGNED 10/29/61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11189
11178
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Howard c. LENGTH OF STAY IN TB 64 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS Arcade Apartments e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAIRD H. VINTON		4. DATE OF DEATH Month October Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Machine shop	
11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward P. Vinton		14. MOTHER'S MAIDEN NAME Eldora Bromwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-07-8370	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) BRONCHOGENIC CARCINOMA, LEFT LUNG, WITH METASTASES X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bronchoscopy - 8/21/61 - Bronchogenic carcinoma, left lower lobe, bronchus	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) August 7, 1961 to October 10, 1961 that (H) (we) last saw the deceased alive on October 10, 1961, and that death occurred at 3:45 P.M. from the causes and on the date stated above.	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from August 7, 1961 to October 10, 1961 that (H) (we) last saw the deceased alive on October 10, 1961, and that death occurred at 3:45 P.M. from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Crahan 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.	
22b. DATE SIGNED 10/11/61		22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/61	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Cemetery		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR OCT 16 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

X

I

100

MARYLAND STATE DEPARTMENT OF HEALTH

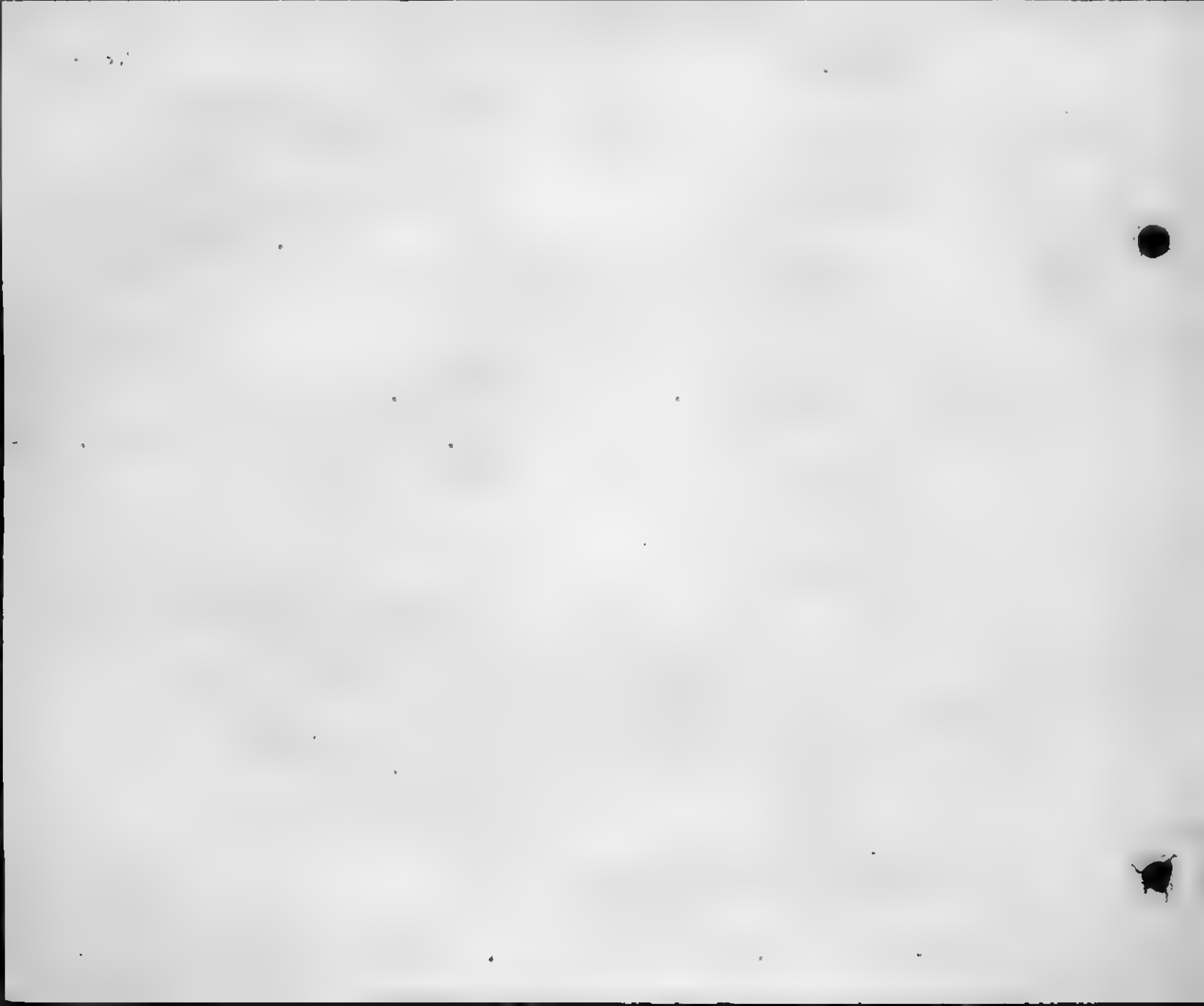
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11190

CERTIFICATE OF DEATH

11179

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1109 Concordia Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 1109 Concordia Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUISE CATHERINE WAGNER First Middle Last		4. DATE OF DEATH Oct. 26, 1961 Month Day Year	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 30, 1921 9. AGE (In years last birthday) 40 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 214-14-7168 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William G. Lentzner, Sr. 14. MOTHER'S MAIDEN NAME Louise C. Hohn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 214-14-7168 17. INFORMANT Robert G. Wagner-1109 Concordia Dr., Towson Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) metastatic carcinoma 180X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypernephroma } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 mos 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Oct 25, 1961 to Oct 26, 1961 , that (I) (we) last saw the deceased alive on Oct 25, 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE George T. Gilmore 22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE		22b. DATE SIGNED 22d. ADDRESS Lutherville, Md. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/30/61 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens 23d. LOCATION (City, town or county) (State) Timonium, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. ADDRESS York Rd., Towson, Md. 25a. REC'D BY REGISTRAR Oct 30 '61 25b. REGISTRAR'S SIGNATURE Arthur L. ...	



TO REGISTERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

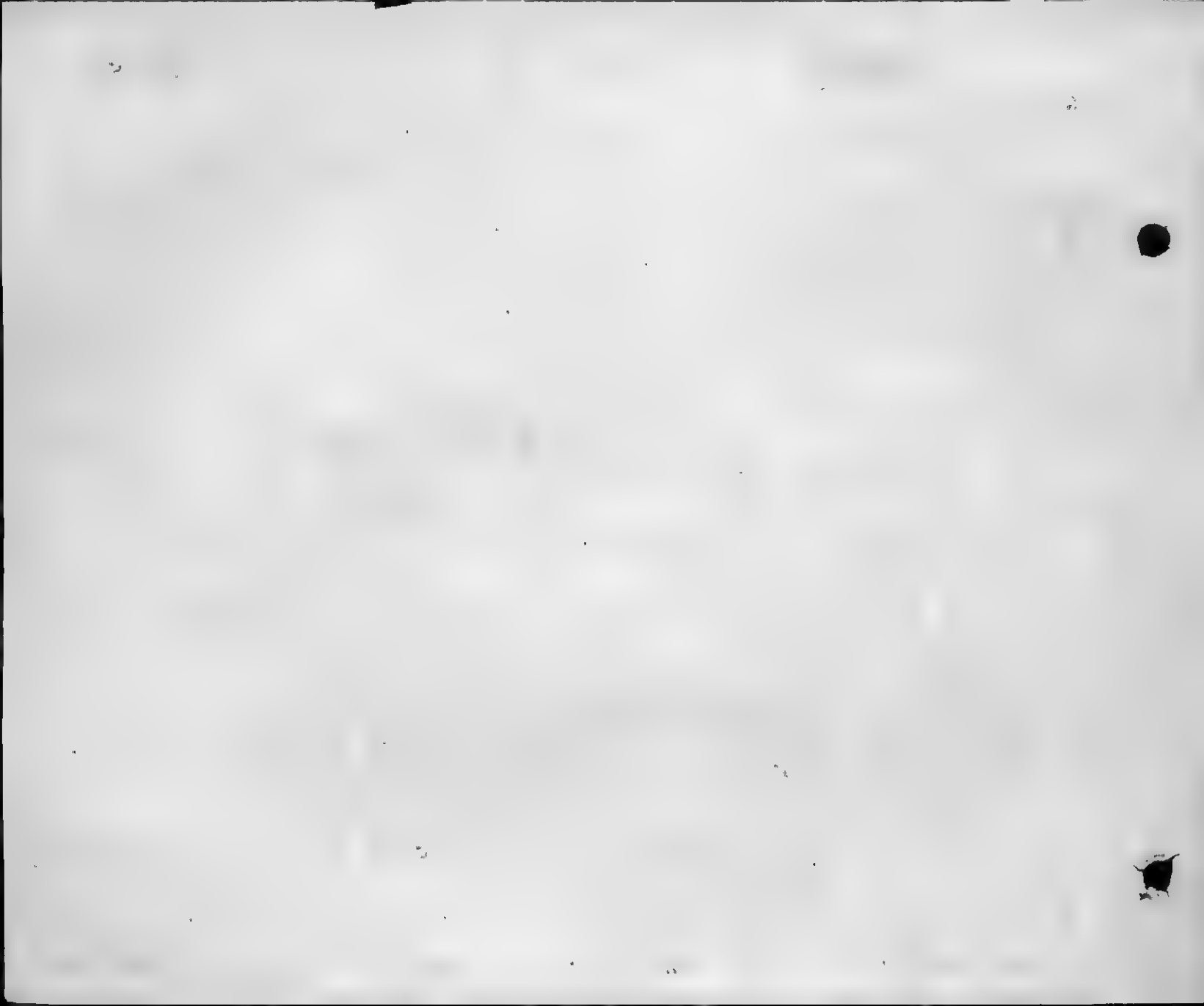
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11191

11180

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14 Tenbury Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dulaney Village, Towson</u> d. STREET ADDRESS <u>14 Tenbury Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>Matthew</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1961</u>		5. SEX <u>male</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 16, 1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance</u>		11. BIRTH PLACE (County & State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Michael J. Ward</u>		14. MOTHER'S M maiden NAME <u>Not known</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219104322</u>		17. INFORMANT <u>MRS MARY REARY</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> DUE TO (b) <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cornary insufficiency, chronic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u> <u>3 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>24 Sept 1961</u> to <u>10 Oct 1961</u>, that (I) (we) last saw the deceased alive on <u>10 Oct 1961</u>, and that death occurred at <u>9A</u> M., from the causes and on the date stated above.					
22a. SIGNATURE <u>Howard Goodman</u>		22b. DATE SIGNED <u>10 Oct 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>	
22d. ADDRESS <u>6604 Hankard Rd Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-14-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24b. ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					



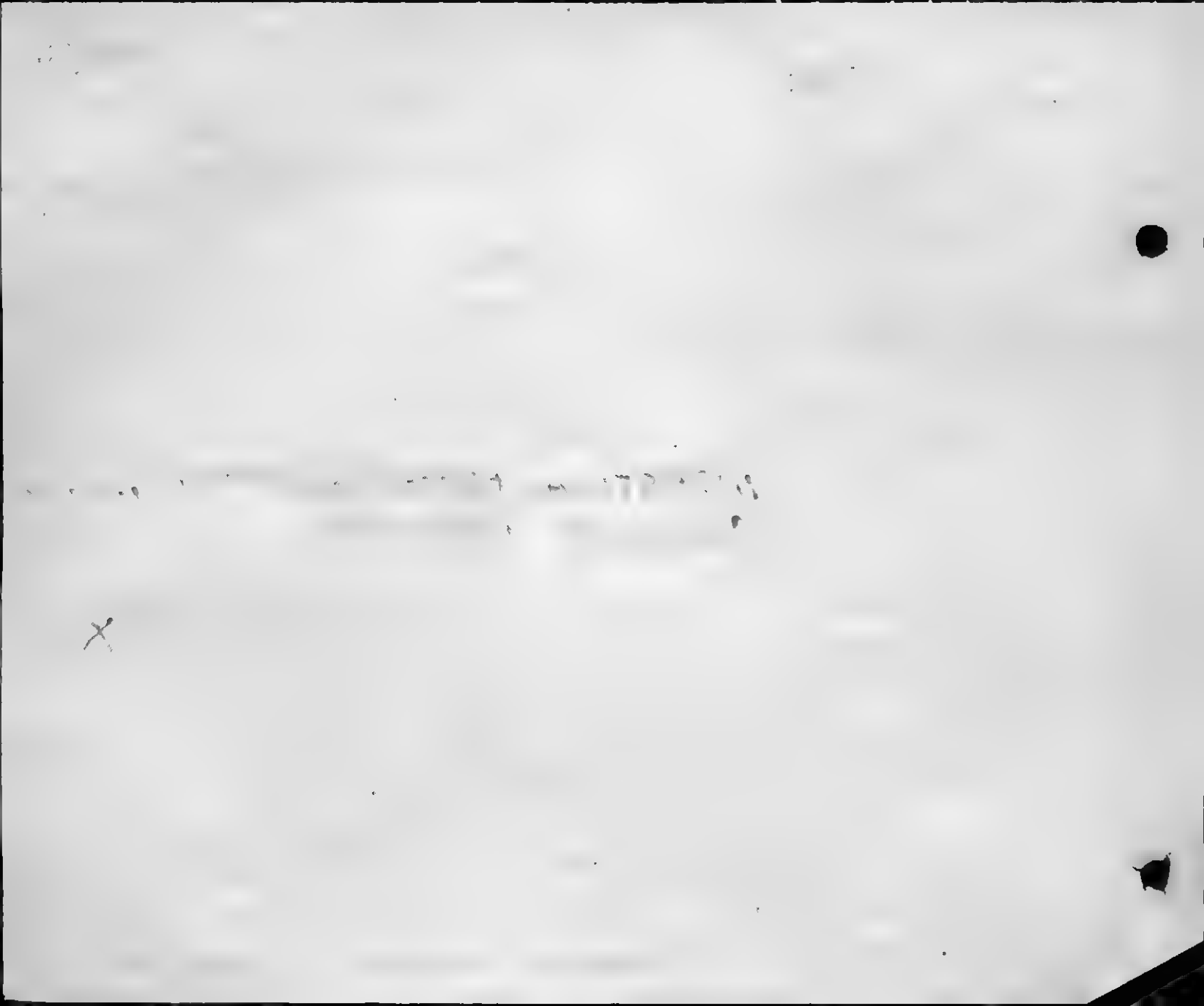
INITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A15 (4)
9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
11181															
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 7yr6mth27dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland d. STREET ADDRESS 4808 Sheridan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Herman Elliott Watson					4. DATE OF DEATH Month October Day 17 Year 1961										
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1911		9. AGE (In years last birthday) 50 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days Hours Min.							
13. FATHER'S NAME Herman Watson					14. MOTHER'S MAIDEN NAME Roxie Smith										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes give war and dates of service)					16. SOCIAL SECURITY NO. 217-32-2640					17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Int DUE TO INTESTINAL HEMORRHAGE (Melena) Conditions, if any, which gave rise to immediate cause (b) Cancer of Pancreas (c) DUE TO Cancer of Pancreas (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 2 days										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 22, 1961 to Oct. 17, 1961 that (I) (we) last saw the deceased alive on Oct. 17, 1961 and that death occurred at 3:25 from the causes and on the date stated above.										22a. SIGNATURE Stella Wachslar, M. D.		22b. DATE SIGNED 10-17-61			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.					22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation Oct 19, 1961			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Forsyth			23d. LOCATION (City, town or county) Georgia			(State)				
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS Hyattsville Md					25a. REC'D BY REGISTRAR Oct 20 '61		25b. REGISTRAR'S SIGNATURE John L. Kneass			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

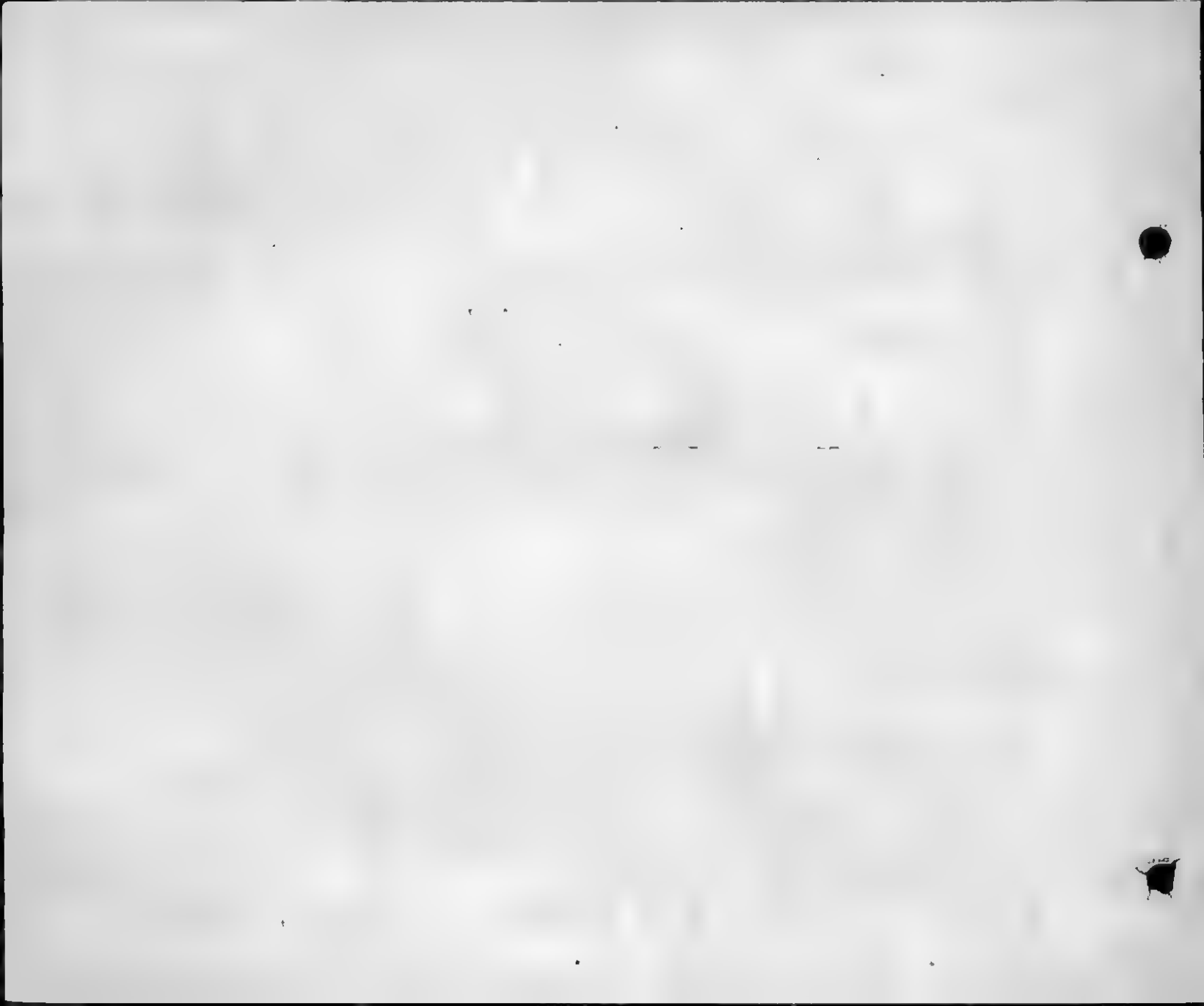
Reg. Dist. No. **11182**

11193

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River #20				c. LENGTH OF STAY IN 1b X Middle River #20			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 69 Cool Breeze Trailer Park				d. STREET ADDRESS 1 69 Cool Breeze Trailer Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John H. Welch				4. DATE OF DEATH Month 10 Day 18 Year 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 3, 1903	
9. AGE (in years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 18 Hours 19 Min.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BoilerMaker				10b. KIND OF BUSINESS OR INDUSTRY Boiler Industry		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 176-03-6347		17. INFORMANT Gladys Welch		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart dis. 420.1 DUE TO 1 1/2 weeks in m Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 1/2 weeks in m DUE TO (c) 1 1/2 weeks in m							INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-18-61	
EXAMINER'S NAME (Type) Jack C. Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdziński				ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR DATE OCT 20 '61	
				24b. REGISTRAR'S SIGNATURE Clifton S. Hanna			

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a preliminary report is necessary, please execute a preliminary report, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

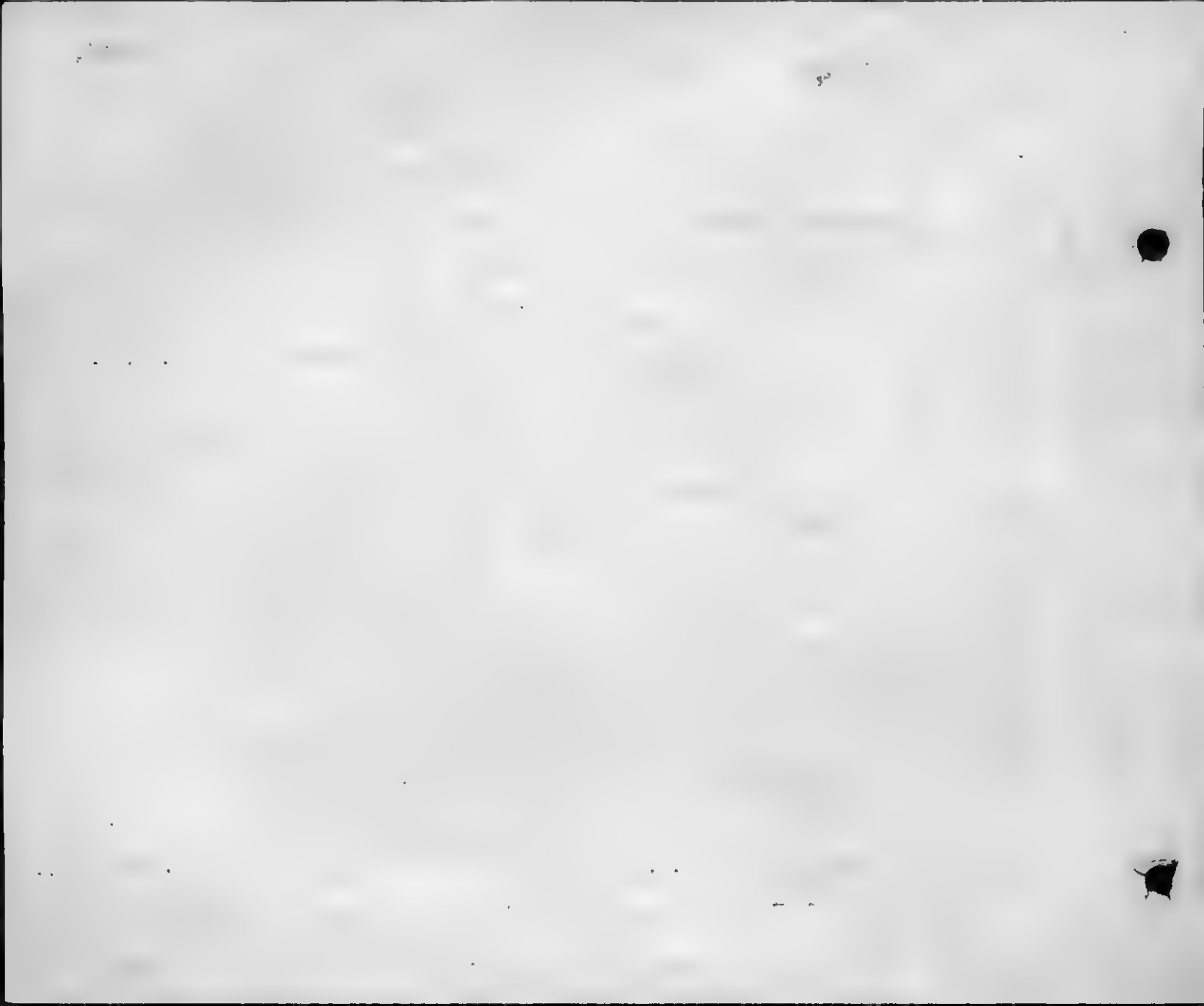
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11194

11183

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b <u>5 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 23</u> d. STREET ADDRESS <u>2223 W. Fayette Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOWARD</u> <u>Male</u> <u>Negro</u> 5. SEX 6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. WIDOWED <input type="checkbox"/> 9. DIVORCED <input type="checkbox"/> 10. DATE OF BIRTH <u>November 23, 1928</u> 11. AGE (In years last birthday) <u>32</u> yrs. 12. IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>1961</u>		13. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u> 16. KIND OF BUSINESS OR INDUSTRY <u>Herman C. West</u> 17. FATHER'S NAME <u>Herman C. West</u> 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u> 19. SOCIAL SECURITY NO. <u>220-20-3999</u> 20. INFORMATION <u>Clinical Records, VAH, Baltimore 18, Maryland</u> <u>FORT HOWARD DIVISION</u>		21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (b) <u>CIRRHOSIS OF LIVER</u> (a), stating the underlying cause last. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>3 Days</u> <u>UNKNOWN</u>	
22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 23a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 24a. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 25a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 26a. (City or town) (County) (State) <u>Baltimore</u> 27a. I certify that (this hospital) attended the deceased from <u>October 8, 1961</u> to <u>October 13, 1961</u> , that (we) last saw the deceased alive on <u>October 13, 1961</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.		28a. SIGNATURE <u>Sebastian Russo</u> 29a. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u> 30a. ATTENDING PHYS. <input type="checkbox"/> 31a. MED. DIRECTOR <input type="checkbox"/> 32a. STAFF PHYS. <input checked="" type="checkbox"/> 33a. DATE SIGNED <u>10/13/61</u> 34a. ADDRESS <u>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</u>	
35a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> 36a. DATE THEREOF <u>10-17-61</u> 37a. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> 38a. ADDRESS <u>Baltimore 28, Maryland</u> 39a. LOCATION (City, town or county) (State) <u>Baltimore</u> 40a. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Cooper</u> 41a. DATE <u>OCT 20 '61</u> 42a. REC'D BY REGISTRAR <u>10/20/61</u> 43a. REGISTRAR'S SIGNATURE <u>James P. Huns</u>		44a. DATE <u>OCT 20 '61</u> 45a. REGISTRAR'S SIGNATURE <u>James P. Huns</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

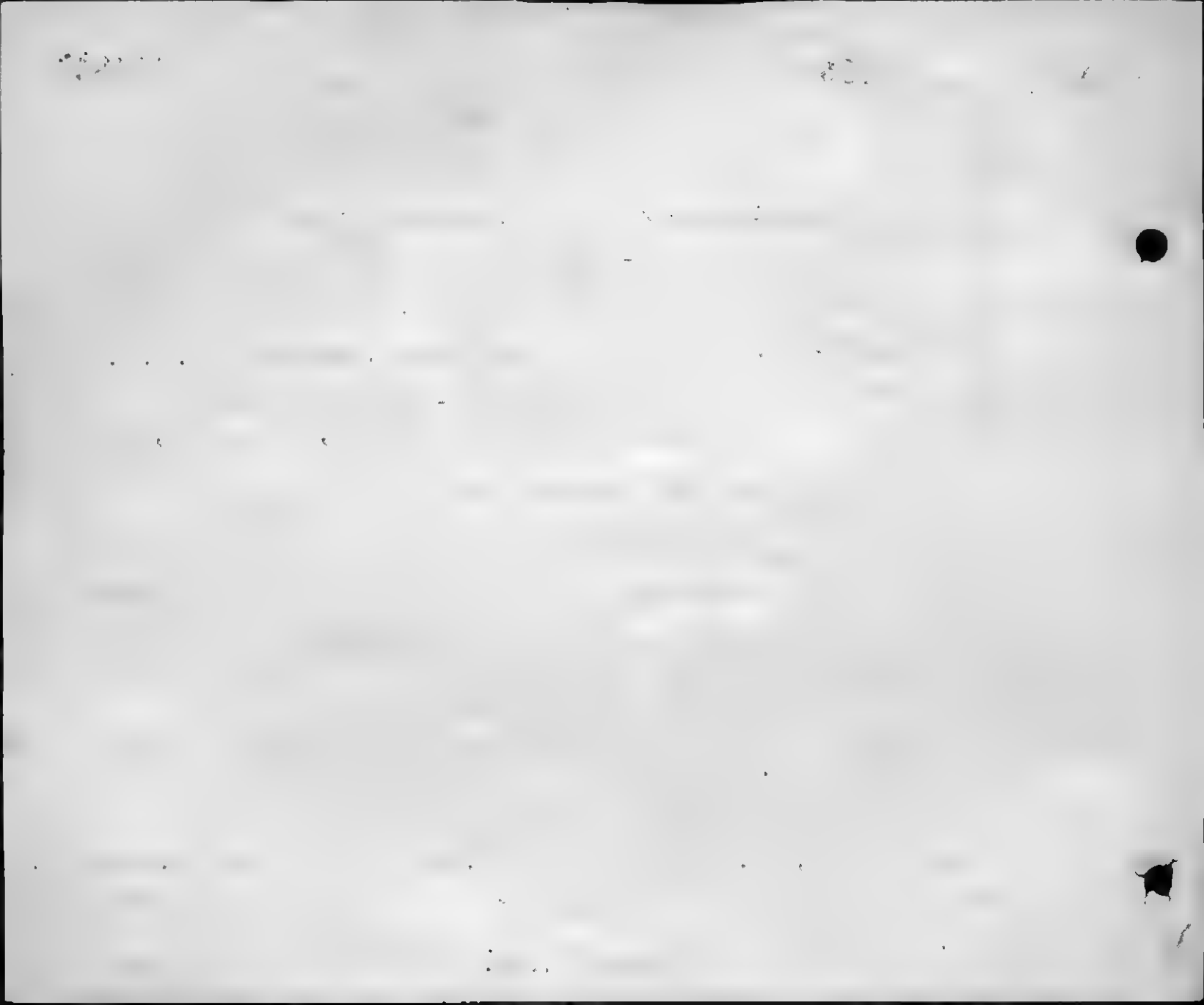
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11195

11184

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1003 Bennett Place	
3. NAME OF DECEASED (Type or print) FERNIE		4. DATE OF DEATH October 3, 1961	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 22, 1889	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator - Ret.		11. BIRTHPLACE (County & State, or foreign country) Washington N. Carolina	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward White		14. MOTHER'S MAIDEN NAME Susan - Maiden name unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-05-6104	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. CRUISE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA Conditions, if any, which gave rise to immediate cause (b) MYOCARDIAL SCLEROSIS DUE TO LUETIC AORTITIS (c) CHRONIC CYSTITIS	
19. INTERVAL BETWEEN ONSET AND DEATH 1 DAY +		20. UNKNOWN UNKNOWN UNKNOWN UNKNOWN	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		26. (City or town) (County) (State)	
27. I certify that U (this hospital) attended the deceased from September 13, 1961 , to October 3, 1961 , that U (we) last saw the deceased alive on Oct. 3, 1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.		28. SIGNATURE Sebastian Russo 29. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.	
30. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		31. DATE SIGNED 10/5/61	
32. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD, DIV.		33. NAME OF CEMETERY OR CREMATORY Baltimore National	
34. LOCATION (City, town or county) (State) Baltimore 28, Maryland		35. BURIAL, CREMATION, REMOVAL (Specify) Burial	
36. DATE THEREOF 10-9-61		37. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson	
38. ADDRESS Funeral Home 1000 Brantley Ave. Baltimore 17, Md.		39. REC'D BY REGISTRAR OCT 11 '61	
40. REGISTRAR'S SIGNATURE William S. Thomas		41. DATE OCT 11 '61	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11196

11185

1. PLACE OF DEATH o. COUNTY BALTO.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b X ESSEX			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION X 908 LUTZ AVE.				d. STREET ADDRESS 1908 LUTZ AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HARRY M WIENEKE				4. DATE OF DEATH Month Day Year OCT. 17 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-85	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BALTO. TRANSIT (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-09-3735		17. INFORMANT Address Mrs. Ethel Bowers (Same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION DUE TO ARTERIO-SCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 20 YRS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 15 1958 to OCT 17 1961 , that (I) (we) last saw the deceased alive on OCT 16 1961 , and that death occurred at 1045 A.M. from the causes and on the date stated above							
22a. SIGNATURE Joseph Miceli				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/20/61	
22c. PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D.				22d. ADDRESS 108 S. TAYLOR AVE BALTO. 21 MD.			
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-20-61		23c. NAME OF CEMETERY OR CREMATORY BALTO. CEMETERY		23d. LOCATION (City, town, or county) (State) BALTO. CITY MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John S. Connelly				ADDRESS 418 Eastern Blvd.		25a. REC'D BY REGISTRAR DATE OCT 23 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13 & 14 Film G-97 10/5/61 iwk

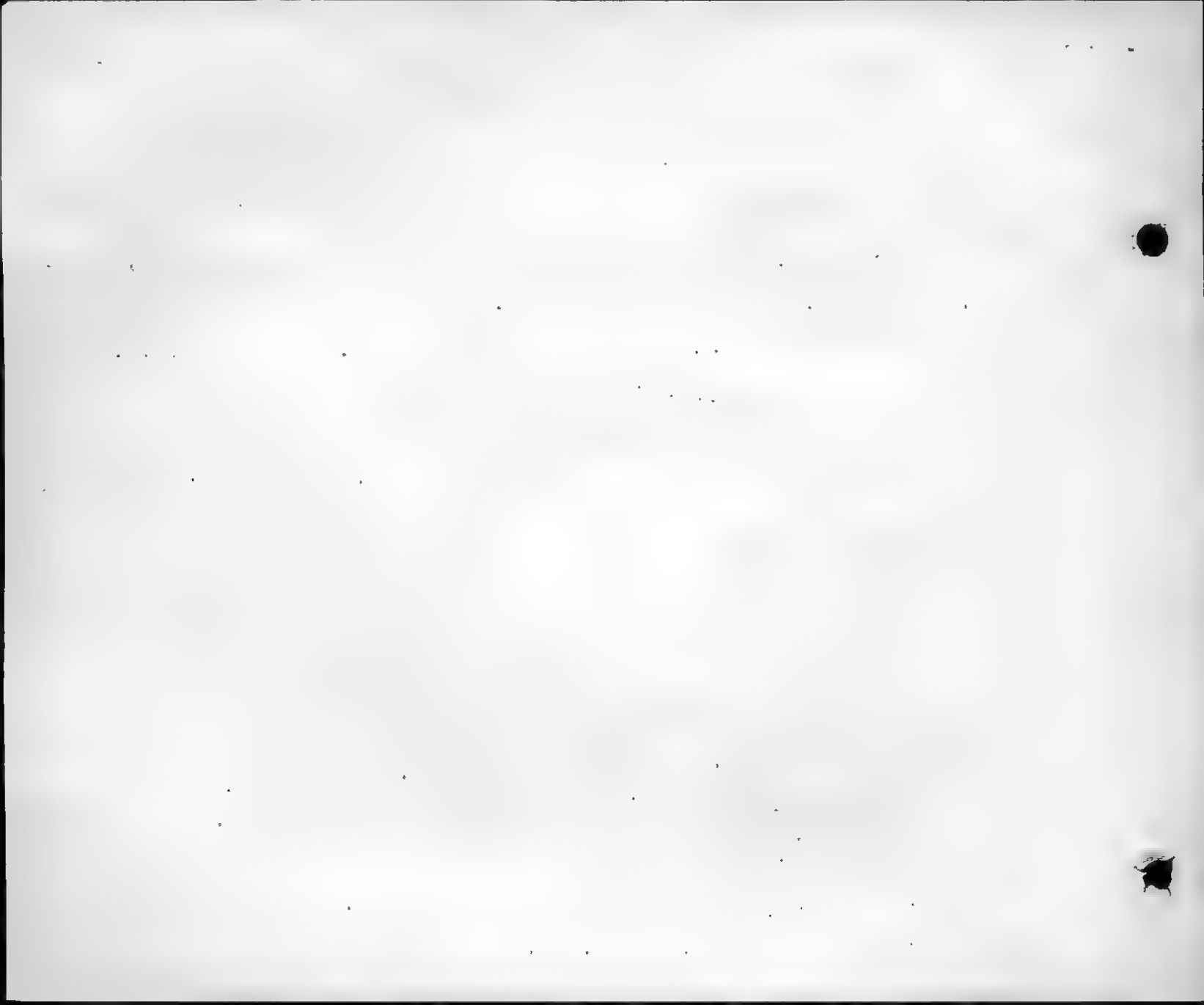
CERTIFICATE OF DEATH

Reg. Dist. No. **11186**

11197

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Two Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1619 Thetford Road		e. STREET ADDRESS 203 McDaniel Avenue	
3. NAME OF DECEASED (Type or print) First Nannie S. Middle Wilder Last Wilder		4. DATE OF DEATH Month October Day 1 Year 1961	
5 SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1885
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Boston Mass.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Joseph N. Pearsall		14. MOTHER'S MAIDEN NAME Harreitt Stiles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT William H. Wilder, 4100 Dudley Ave. Balto. 6 Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) 24 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 1, 1961 to Oct 1, 1961 , that I last saw the deceased alive on Oct 1, 1961 , and that death occurred at 9 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph F. Lipira		DATE SIGNED 10/2/61	
PHYSICIAN'S NAME (Type) Joseph F. Lipira		ADDRESS (Street, city or town, state) 8400 Loch Raven Blvd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/4/61	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.		24a. REC'D BY REGISTRAR Oct 3 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

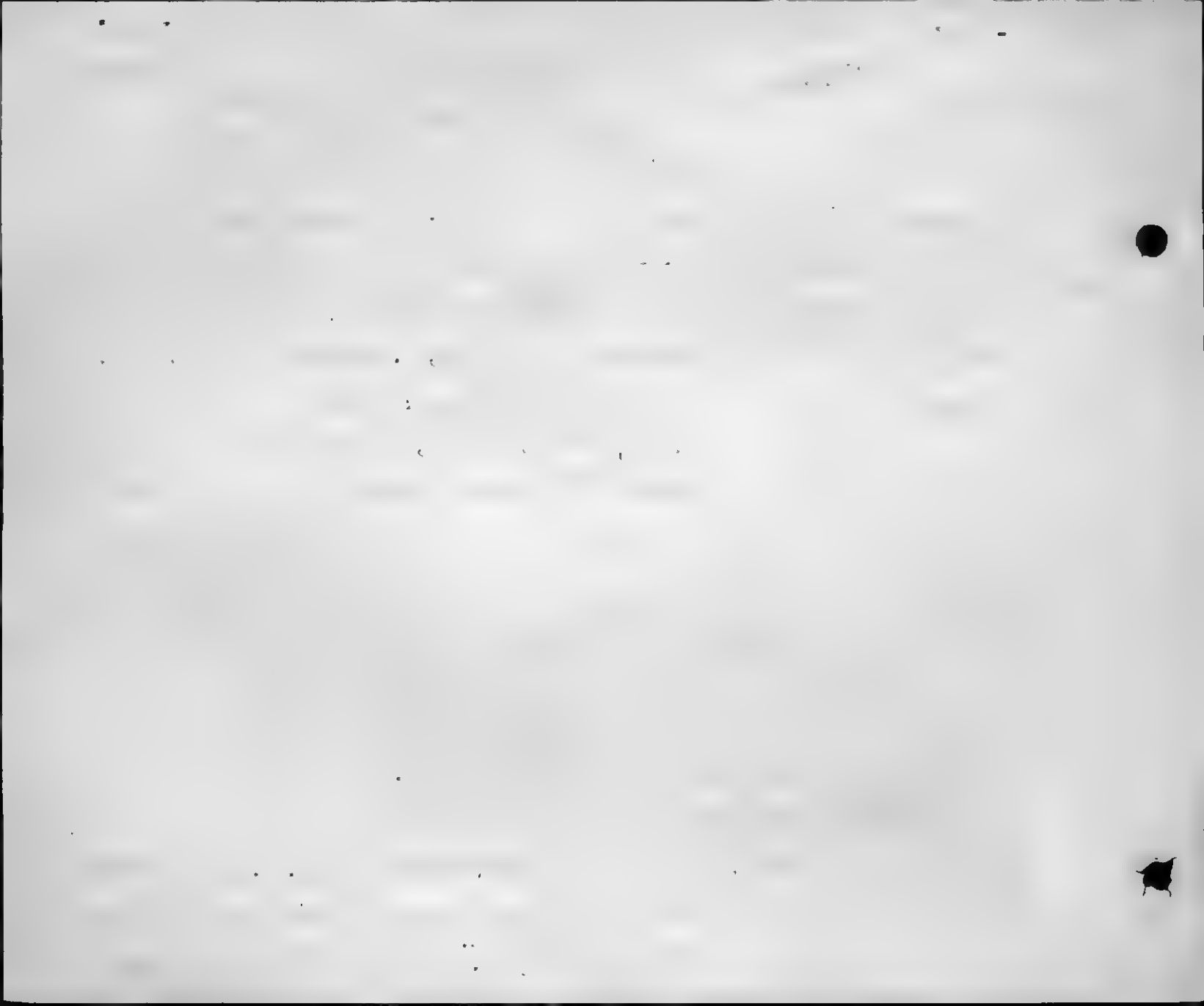
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

11198

11187

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 d. STREET ADDRESS 1809 E. Lafayette Avenue				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First --- Middle WILSON Last				4. DATE OF DEATH October 4 1961		Day Year			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1892			
9. AGE (In years last birthday) 68 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Sumter, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Daisy M. Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 217-20-4791					
17. INFORMANT Clinical Records, VAH, Fort Howard Division Baltimore 18, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL TUBERCULOUS PNEUMONIA DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 30, 1961 , to October 4, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 4, 1961 , and that death occurred at P.M. from the causes and on the date stated above.									
22a. SIGNATURE Sebastian Russo, M.D.				22b. DATE SIGNED 10/5/61		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-9-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson Funeral Home				25a. REC'D BY REGISTRAR DATE OCT 11 '61		25b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

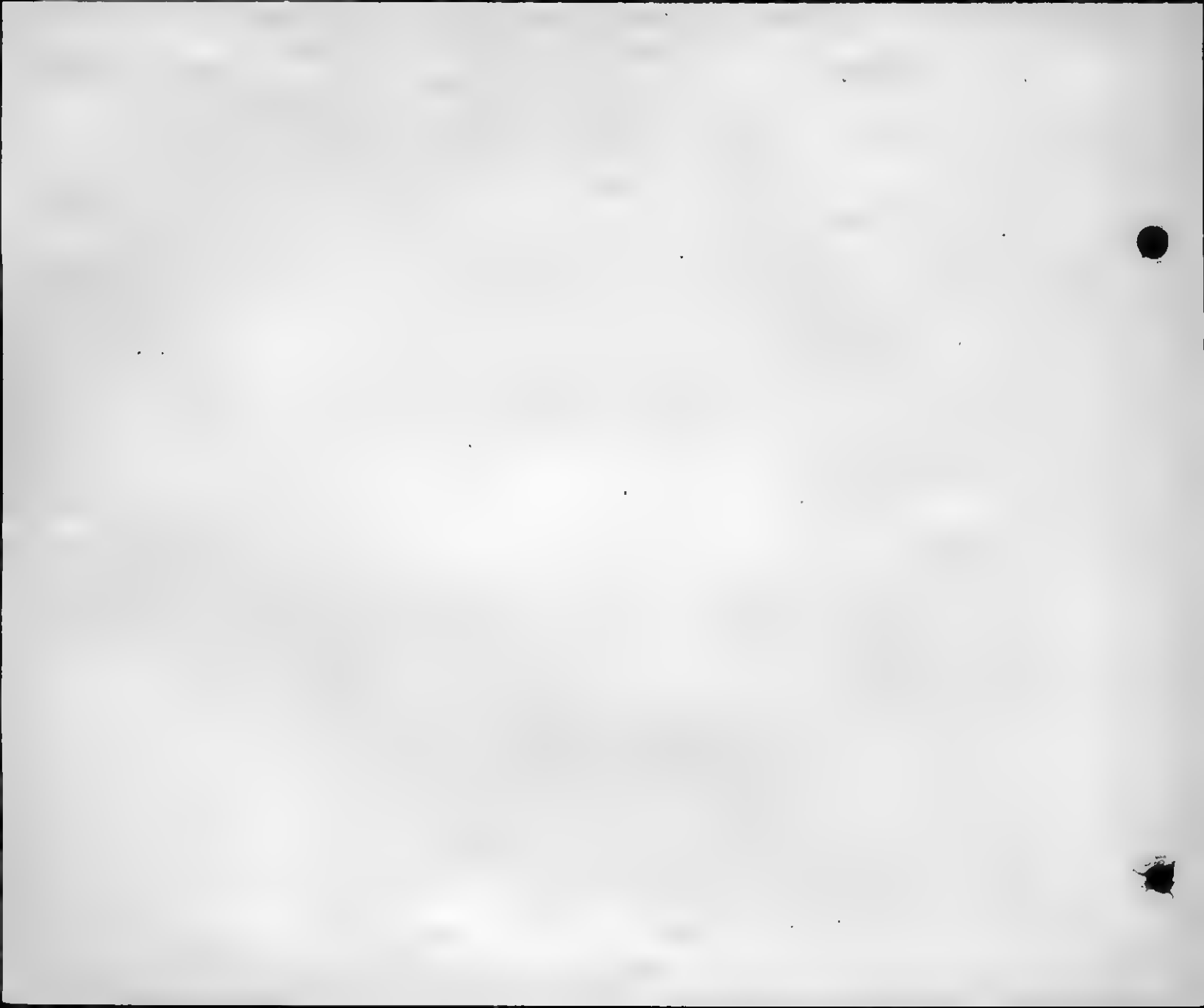
Reg. Dist. No. **11188**

11193

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7040 Dunbar Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Walter H. Wilver				4. DATE OF DEATH Month Day Year October 15 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1899		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY steel		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wilver				14. MOTHER'S MAIDEN NAME Cora — Stahl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lillian E. Wilver, 7040 Dunbar Rd., Dundalk 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colonic Occlusion 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extramural Intestinal Obstruction DUE TO (c) Extramural Intestinal Obstruction						INTERVAL BETWEEN ONSET AND DEATH 16 hrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 16 hrs							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Oct. 18, 1961		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home, Dundalk, Maryland				24a. REC'D BY REGISTRAR OCT 19 61		24b. REGISTRAR'S SIGNATURE 16-15-61	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11133. Page 11 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11200

11189

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>2 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1642 ABERDEEN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>1642 ABERDEEN RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LETTIE CATHERINE WOOD</u> First Middle Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>APR. 18, 1881</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>OCT. 10 1961</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sorter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PETERSBURG, VA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>GEORGE MYERS</u> 14. MOTHER'S MAIDEN NAME <u>ROSA V. BROCKWELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>213-09-9249</u> 17. INFORMANT <u>FLORENCE G. MORROW</u> Address <u>1642 ABERDEEN RD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 3. X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Sept. 21, 1961</u> , to <u>OCT. 10, 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Oct 9, 1961</u> , and that death occurred at <u>10</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles V. Sevcik</u> 22b. PHYSICIAN'S NAME (Type) <u>DR. CHARLES SEVCIK</u> 22c. DATE THEREOF <u>10/13/61</u>		22d. ADDRESS <u>5101 BELAIR RD.</u> 22e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> 22f. REGISTRAR'S SIGNATURE <u>10/10/61</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10/13/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u> 23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>		25a. REC'D BY REGISTRAR <u>Oct 11 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11190

11201

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital, Catonsville</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1250 Maple Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>William H Wright</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>1st</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>From Moulder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B + O. R. R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Owen Wright (dead)</u>		14. MOTHER'S MAIDEN NAME <u>Louise Wright (deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Melvin Wright (son)</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>possibly pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>bad nutritional state</u> (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 29, 1961</u> to <u>OCT. 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>OCT. 1, 1961</u> , and that death occurred at <u>2:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Loretta Hsu</u>		22b. DATE SIGNED <u>10-1-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LORETTA HSU</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Foulkner Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Imbrux, Inc. 1328 Sulphur Spring Rd.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 4 '61</u>	
ADDRESS <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

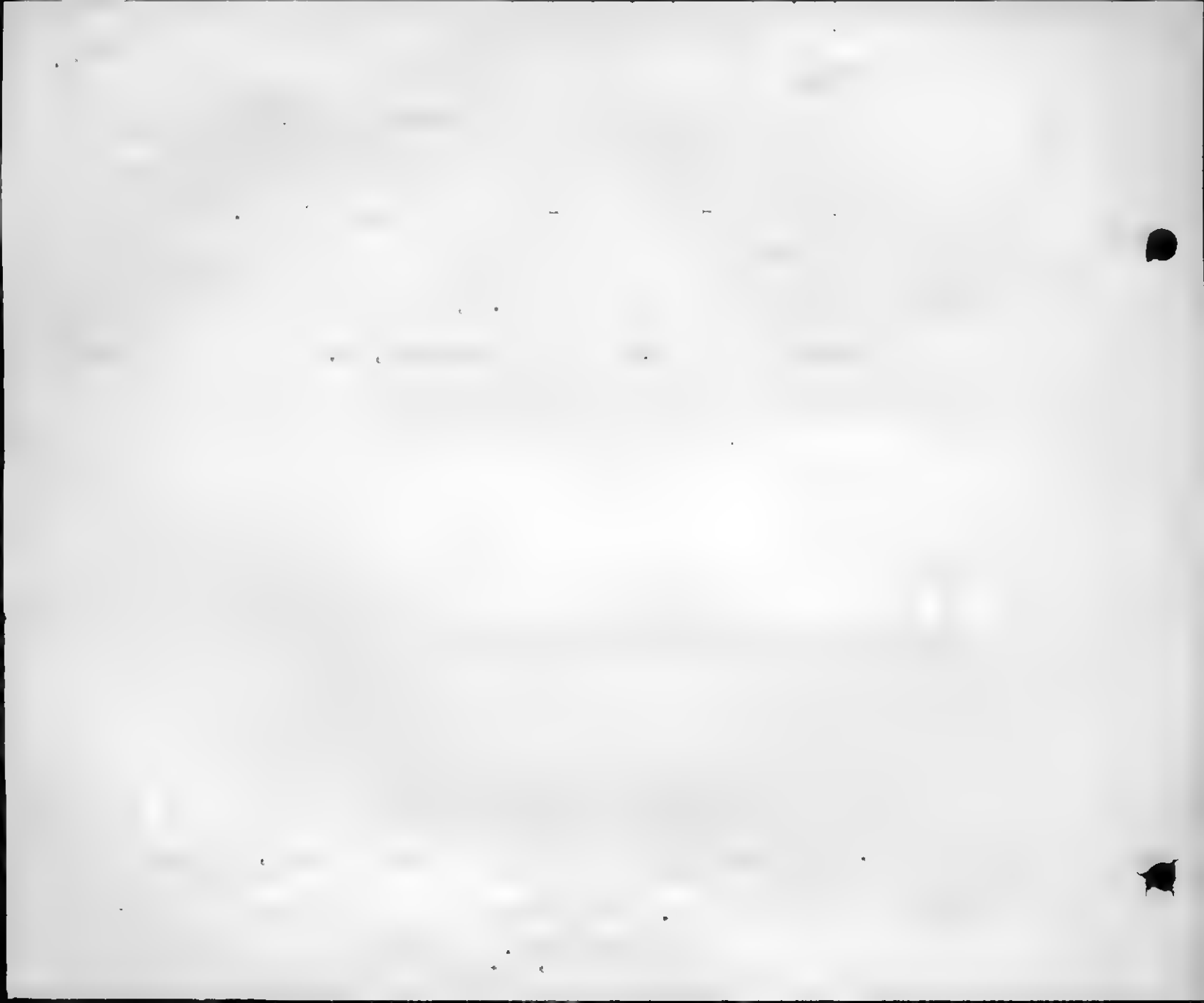


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11191

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McDonogh School - Pikesville		d. STREET ADDRESS 6746 Windsor Mill Rd.	
3. NAME OF DECEASED (Type or print) First Clara Middle Younger Last Younger		4. DATE OF DEATH Month Oct Day 26 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1887
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 28 Days 28 Hours 28 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Hebbville, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Riddle		14. MOTHER'S MAIDEN NAME Annie Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-32-0658	
17. INFORMANT Mr. William E. Younger		Address 5 Wumore Rd. Baltimore 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO 15' X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Diabetes mellitus (b) D DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1946 to Oct 26, 1961 , that (I) (no) last saw the deceased alive on 24 Oct 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul H Royse		22b. DATE SIGNED 26 Oct 61	
22c. PHYSICIAN'S NAME (Type) Dr. Paul Royse		22d. ADDRESS Pikesville 8, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/28/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City, town, or county) (State) Randallstown Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR OCT 30 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director, retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11192

1

11/28

11/28

(1)

There is a small amount of water in the tank.

The water is clear and the tank is clean.

The water is clear and the tank is clean.

The water is clear and the tank is clean.

The water is clear and the tank is clean.

The water is clear and the tank is clean.

The water is clear and the tank is clean.

The water is clear and the tank is clean.

11/28

The water is clear and the tank is clean.

The water is clear and the tank is clean.

The water is clear and the tank is clean.

1
8
M
X
1

11204

11193

1

11204

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reistertown		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berrymans Lane Box 328 Rt. 2		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reistertown	
		d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) First William Middle Clifford Last Zimmerman		4. DATE OF DEATH Month Oct. Day 11 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jul. 24, 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Zimmerman		14. MOTHER'S MAIDEN NAME Mary Talley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 296-09-8452	
17. INFORMANT Mrs. Frank Jones		Address Berrymans Lane Rt. 2 Box 328	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 6-27-44 , 19____, to 10-11-61 , 19____, that (I) (we) last saw the deceased alive on 10-10-61 19____, and that death occurred at 8P M, from the causes and on the date stated above.			
22a. SIGNATURE D. D. Caples		22b. DATE 10-12-61	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF Oct. 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Mausoleum		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichauer & Son, Inc. North & E. Pk. Balt. 17 Sp.		25a. REC'D BY REGISTRAR DATE OCT 13 '61	
25b. REGISTRAR'S SIGNATURE William L. Thomas			

D.S.M.

11198

STATE OF TEXAS

11504

M